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Full Name of Author — Nom complet de l'auteur

PEGGY-ANNE FIELD

Date of Birth — Date de naissance

14 JULY 1932

Country of Birth — Lieu de naissance

ENGLAND

Permanent Address — Résidence fixe

12060 25 AVENUE
EDMONTON
T6J 4L3

Title of Thesis — Titre de la thèse

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AN ETHNOGRAPHY: FOUR NURSES' PERSPECTIVES OF NURSING IN A COMMUNITY SETTING

by

©

PEGGY-ANNE FIELD

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
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THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled AN ETHNOGRAPHY: FOUR NURSES' PERSPECTIVES OF NURSING IN A COMMUNITY HEALTH SETTING submitted by PEGGY-ANNE FIELD in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Elementary Education.

Supervisor

Marion D. Jenkinson

Valerie J. Janesick
External Examiner

Date October 7, 1980

DEDICATION

To the four nurses who participated in this study and to all their clients; to my parents, who have remained interested in my work over many years of geographical separation; and to four outstanding teachers, the late Marjorie Browne, Winifred Andrews, Evelyn Matheson and Jacqueline Holt-Vandeman.

ABSTRACT

The purpose of this study was to describe four nurses' perspectives of nursing. This study described the statements and actions of four nurses over a period of five months. The nurses' definitions of the situation, and their actions and criteria of judgement provided evidence for their perspectives of nursing. Four exploratory questions guided the study: 1) What elements constitute each nurse's perspective of nursing in the practice setting? 2) Which contextual variables outside and inside the situation of the nurse-client interaction influence each nurse's perspective of nursing? 3) What are the assumptions that each nurse makes about clients and nursing intervention which support, or are contrary to, her perspective of nursing? 4) How does each nurse synthesize the various types of information about the client and his/her background into her perspective of nursing?

This study was based on the theory of symbolic interaction. The researcher placed herself in the nurses' environment, taking a limited role in community nursing activities, and observed the informants from many vantage points. The four major informants were volunteers. The focus of the observations was on the nurse-client visit. The researcher took the role of participant-observer, utilizing observation, formal and informal interview, client records and clinic reports to collect data.

The data were analyzed on an on-going basis to identify relationships within the data that would merit further study. Final analysis was undertaken following the completion of field work.

Each nurse had a perspective of nursing which she used as a model to guide her practice. While there were common elements across models the organizational relationships were unique to each individual. The primary influence on the model appeared to be the nurse's own life experience and priorities. Once a perspective developed it appeared to be relatively resistant to outside forces. It is probable educational programmes reinforce beliefs but only have a minimal effect on changing them. When agency policies conflicted with the nurses' beliefs they devised strategies for circumventing the policies. While nurses could identify their beliefs they did not recognize that their frustration with clients might be vested in values conflict. The nurses in the study did not always have the skills and/or knowledge to operationalize their internalized beliefs. Nursing situations were complex and problems were of a problem-to-find as well as a problem-to-solve nature. A lack of feedback from clients, supervisor or peer group members on the effectiveness of nurse-client interventions did not lead nurses to question the effectiveness of their models. The researcher concluded that while it would be inappropriate to generalize from four cases there was evidence to show that all four nurses utilized a conceptual model to guide their practice, that these models were relatively resistant to change and that the main influence on model development was the nurse's own life experience. It was also

concluded that the ethnographic approach utilized in the study was an appropriate method for studying nursing in the context of the practice setting.

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CHAPTER 1

OVERVIEW OF THE STUDY

Introduction

As a vital member of the multidisciplinary health care team, it is critical that nursing identifies and clarifies its unique contribution to society. We do not know how nursing meets society's needs, nor do we really understand what it is that nurses do or the rationale that an individual nurse uses to select a specific nursing action (CNA Project Report, 1980).

Studies of nursing practice have tended to be limited to the examination of specific nursing actions, rather than observations of nursing. Follow-up studies of nursing graduates by educational institutions have tended to utilize techniques such as questionnaires and interviews based on the goals and objectives of the educational programmes from which the practitioners have graduated. These studies identify whether or not the graduates achieve the goals of the educational programmes, but do not identify the manner of practice (Hayter, 1963, 1971; Kramer, 1974; Parker and Humphreys, 1970, 1971, 1973; Peitchinis, 1975). Yet nursing is a social act involving the nurse and one or more clients that occurs within a recognizable context. Because the core of any profession lies in its practice, to understand nursing it is necessary to study practice within the contextual setting.

An overview of educational research demonstrates the difficulties involved in the study of teaching. It would seem that there are similarities between the need to study the end-product of teacher education programmes, the teacher in the context of the classroom situation (Nuthall, 1974; Nash, 1976; Shulman, 1977), and the need to study the end-product of nursing education programmes, the nurse, in the context of the care-giving situation. Education occurs in a social environment and one cannot separate the act of teaching from the environment if one is to understand what is occurring (Rothe, 1979) and this has become an important principle in recent studies of teacher activity in the classroom (Boag, 1980; Connors, 1978; Cooper, 1979; Janesick, 1977). In examining the act of nursing it would appear probable that the same premise holds true, as both teaching and nursing depend on individuals using interaction skills within a social context.

Many recent educational studies of teachers and classrooms utilize ethnographic methods with participant observation as a central data gathering technique. While participant observation has been used in examining specific clinical problems in nursing settings, it has rarely been used in studying nurses at work. One exception is an English study in which the socialization of health visitor students was analyzed. It was concluded that socialization was influenced to a greater degree by the work situation than by the content or values of the educational programme (Dingwall, 1976).

An ethnographic study of nursing will provide new information on nursing practice that will help nurses understand the factors that influence and direct the nurse as she provides client care.

Purpose of the Study

For nursing practice to be understood it must be examined in the context within which the practice occurs. This study was an exploration of four nurses' perspectives of nursing in a community setting and a description of the nurses' behavior as they provided care to clients during the course of their working day. In order to understand the nurses' interpretative process, their decisions, and their actions, it was necessary conceptually to isolate the nurses' perspective on nursing.

Need for the Study

A conceptual model for nursing is a mental image or a way of looking at nursing usually based on, or derived from, theory and/or practice (CNA Project Report, 1980, p. 4). The purpose of a conceptual model is to clarify nursing's unique independent role. Nurse educators have given much time and effort to the development of such models and the assumption has been made that their use by the nurse, to guide her practice, will improve nursing care. Current models of nursing are built on both inductive and deductive reasoning and, for the most part, lean heavily on concepts from sociology, psychology, and physiology, which are then reinterpreted to form the basis of nursing theory (King, 1971; Orem, 1971; Rogers, 1970; Roy, 1976). It is believed that a better understanding of the practice of nursing within its contextual constraints could ultimately lead to diagnostic theories of practice which would enable us to answer the questions "What do nurses do?" and "Why do they do it?"

For some years nursing has leaned heavily on experimental and survey research. Currently some nurse-researchers are suggesting nurses need to seek alternative approaches to research and the study of nursing practice (Crawford, Default and Rudy, 1978; Donaldson and Crowley, 1978; McKay, 1977; Stinson, 1979). Recent experience in the study of teachers in the classroom suggests that ethnographic methods have utility for exploring disciplines in which human interaction provides the core of practice. Although such methods have been used by anthropologists for many years, only recently has the method been utilized by other disciplines. In this study nursing was examined from the perspective of the practitioner, who was regarded as a rational individual able to explain his/her thoughts and actions.

Statement of the Problem

The focus of this study was the nurse's perspective of nursing and its relationship to nursing action. Due to the exploratory nature of the study a number of wide-ranging questions were raised:

1. What elements constitute each nurse's perspective of nursing in the practice setting?
2. Which contextual variables outside and inside the situation of the nurse-client interaction influence each nurse's perspective of nursing?
3. What are the assumptions that each nurse makes about clients and nursing intervention which support, or are contrary to, her perspective of nursing?

4. How does each nurse synthesize the various types of information about the client and his/her background into her perspective of nursing?

Given the nature of the research design, the above questions were considered a set of "working hypotheses" (Geer, 1964). They were not, as in the experimental method, a set of hypotheses to be statistically tested but a set of statements that acted as a guide for observation in the field.

Theoretical Framework

Given that the problem for study was the nurse's perspective of nursing, a method of approach was needed that viewed human behavior, that is, what people say and do, as a product of how people interpret their world. The particular theory chosen is the social psychology of symbolic interaction which serves as a heuristic tool for studying the social reality of the individual. Symbolic interaction has many interpretations but the perspective adopted here is based on the tradition of Howard Becker (1961), Herbert Blumer (1969), Blanche Geer (1964) and Everett C. Hughes (1958). The work of Goffman (1959) has also been utilized.

The original concept of symbolic interaction was developed by a social psychologist, George Herbert Mead (1934). His ideas on the relationships between the subject, the object, and the development of self are the basis of symbolic interaction theory.

The symbolic interactionists operate on three major premises: that the human being has a self; that human action is constructed by that self, and that human action occurs within a social setting. In contrast to structural and functional theorists, symbolic interactionists maintain that people act toward situations, not toward culture, social structure, or the like (Blumer, 1967, p. 145). Therefore symbolic interaction is a process of interpretation between individuals (Meltzer, Petras and Reynolds, 1975; Blumer, 1967). In stating that the human being has a self, Mead (1934) indicated that the human being can be an object of his own actions. In symbolic interaction this fact is seen as the central mechanism through which the human being faces and deals with his world (Blumer, 1967). Anything of which an individual is conscious, he is indicating to himself. This ability to interpret to oneself also enables the individual to interpret the actions of others by pointing out to oneself that the action has this as their meaning or character.

Blumer (1967) argued that the process of self-indication differs from a concept of response to a stimulus in that it can not be explained in terms of environmental pressures, external stimuli or organic drives. When an individual indicates something to himself it becomes an object to which he has given meaning. It is therefore a product of the individual's predisposition to act, rather than an antecedent stimulus which evokes an act. The actor interprets or acts on the basis of symbols to which he gives his own meanings, and these meanings are related to the ongoing activity in his social world. Action is conscious and takes account of the demands, the prohibitions and the threats, as they arise in the situation in which the actor is acting. Actions arise, therefore, from the actor's interpretation of the stimuli and not as a result of the stimuli themselves.

The implication of this is that action is constructed and built up by the individual. Blumer (1967, p. 142) describes the process as follows:

> Whatever the action in which he is engaged, the human individual proceeds by pointing out to himself the divergent things which have to be taken into account in the course of his action. He has to note what he wants to do and how he is to do it; he has to take account of the demands, the expectations, the prohibitions, and the threats as they may arise in the situation in which he is acting. His action is built up step by step through a process of self-indication. The individual pieces together and guides his actions by taking account of different things and interpreting their significance for his prospective action.

Thus, the actor notes things, assesses them, gives them a meaning and then acts on the basis of his decisions. In self-indication the actor points out to himself what is happening in his world, then interprets the experience or the expression of things noting the given social demands made on him.

Formation of action through a process of self-indication takes place in a social context, so that an individual aligns his actions to the actions of others by ascertaining the meaning of the other's acts. The manner in which an individual guides his choice of actions by self indication thus rests on his interpretation of their potential significance in terms of his definition of the situation.

The consistency with which an individual defines a succession of situations depends on his personal perspective (Shibutani, 1967). Each individual constructs an ordered view of the world which is taken for granted by that individual. For the interactionist, a perspective is a socially derived interpretation of that which is encountered, which serves as a basis for the actions to be constructed (Janesick, 1977). One's perspective is a combination of beliefs and behaviour that is constantly modified by social interaction.

In terms of the interactionists, when working with clients the nurse will act and think in a particular way. She will develop a perspective on nursing, a consistent way of thinking and acting in nursing situations. This perspective will enable nurses to make sense of, interpret and construct their actions in response to the nursing situation.

Assumptions of the Study

1. That the human being has a self whereby he defines his situation and identifies the meaning of his social reality.
2. That the individual can explain to others the reasons for his behavior.
3. That, if the individual normally behaves in a manner that supports the veracity of his statements, it is highly probable that his responses will be reliable in the research situation.

Definition of Terms

In this study the following terms will be used as defined:

Perspective:	The co-ordinated views and plans of action people follow in preactive situations (Mead, 1938).
Group Perspectives:	Those perspectives held collectively by a group of people.
Client:	The client may be any individual or family (e.g., mother-father, pre-schooler) with whom the community nurse interacts in her professionl role.

Performance: "All the activity of a given participant on a given occasion which serves to influence, in any way, all of the other participants" (Goffman, 1961, p. 15).

Context: The characteristics of the working environment.

Symbolic Interaction: "A process of interpretation between human beings based on the belief that all things have meanings for the individual and that these meanings derive from the social interaction one has with one's fellows" (Blumer, 1969, p. 2).

The Visit: The interactive phase of nursing where the nurse and client meet in a face-to-face encounter.

Biography: The cumulative data one individual collects on another which forms a profile of the other, enabling one to know what to expect in a situation.

Methodology

Given the problem central to this study and the theoretical base, it was necessary to select a methodology that would allow direct observation of the subjects. The method also had to be such that it would provide extensive data that would allow the researcher to catch the process of interpretation by which the subjects in the study construct their actions. Blumer (1967) notes that one can only determine the process of interpretation by seeing it from the viewpoint of the actors, and that this can only be achieved by observing the actors as they construct their actions and then translate them into acts. One must observe how subjects make decisions as they interpret and construct their social reality. To achieve these conditions in this study the researcher took the role of a participant observer in a community health setting. The observer participated in all activities, both professional and social, that were central to the social reality of being a nurse in the selected context, but did not take on the role of a nurse.

Participant observation is a definable role, the purpose of which is to gather information along with a set of behaviors related to the group of which the observer becomes a member (Gold, 1969). The goal of such participant observation is valid, verified data, analyzed in a manner which is scientifically sound but which respects the rights of human beings (Pearsall, 1965). The advantage of using an ethnographic approach in this study is that the observations are conducted over a prolonged period of time, providing in-depth contact with the informants. The culture of public health nursing is described in the language and from the point of view of the participants (Spradley and McCurdy, 1972). This method is compatible with the demands of a symbolic interaction framework.

In this study four nurses in one community health clinic were observed for a period that extended over five months. Each nurse was observed intensively for a minimum of fifteen days spread over the five month period, but peripheral involvement was maintained with all subjects over the total study period. The nurses were observed in both work and social situations; they were observed in the clinic, on home visits and in the schools. They were observed as they nursed both individual clients or worked with groups of clients. One nurse transferred to another clinic half-way through the study, but observations were continued in that clinic until the study was completed.

Data were gathered through the use of extensive fieldnotes, tape-recordings of nurse-client interactions and interviews. Both non-verbal and verbal behaviors were recorded. A weekly analysis was carried out, and once a month fieldnotes were discussed with a colleague to check on the possibility of a bias in interpretation. As analyses proceeded concepts were inferred from the data and tentative hypotheses generated. Interviews with other informants, both internal and external to the clinic, were also carried out. The proximity of the researcher to the nurses enabled the researcher to catch the processes of interpretation of situations in relation to the actions as the study proceeded.

Limitations of the Study

1. This study is limited to nurses working in an urban community health situation that incorporates home, school and clinic settings.
2. The study is focussed on the nurse's perspective rather than the perspectives of both nurse and client.
3. The subjects are volunteers and therefore may be atypical of the population as a whole.

Organization of the Thesis

This thesis is organized into nine chapters. The first three comprise the introduction, a literature review which mainly focussed on the methodology, and a description of the method itself. Chapter 4 presents the setting in which the four major informants are employed and the beliefs about nursing held by their colleagues. Chapters 5, 6, 7 and 8 consist of case studies, each chapter concentrating on the perspective of one of the four nurses. The final chapter presents the discussion, conclusions, and implications for nursing from the study.

CHAPTER 2

REVIEW OF THE RELATED LITERATURE AND RESEARCH

This review of the literature is divided into three sections. The first section reviews trends in nursing research as applied to methodology and community health nursing. The second section is a review of nursing research studies that have used observational techniques, examining the strengths and weaknesses of the approach. The third section focusses on some selected studies in education in which an ethnological approach has been utilized. The implications of such an approach for this study will be outlined.

Current Trends in Nursing Research

A general survey of the field of nursing research is a difficult task due to the wide range of topics selected for study and the variety of approaches used for classification. Consequently this review will thus be limited to examining trends in methodology with specific emphasis on community health nursing.

Stinson (1979) maintains that no single academic or professional discipline reflects the use of such wide-ranging methodologies as does nursing, although the majority of nursing research literature tends to centre more heavily on the quantitative realm. This may be the reason for the criticism by DeTornyay (1976) of the unevenness and hodgepodge nature of much nursing research. It has been suggested that, in an effort to be scientific, the nurse researcher has often selected an approved methodology and then sought the nursing question which lends itself to that methodology. This in turn has led to trivial research which has failed to identify significant nursing questions (Stevens, 1978).

There is also criticism of an approach to research where reliance is placed solely on traditional empirical methods; the use of a deductive approach to hypothesis formation, large statistical samples and an analytic framework based on a quantitative design. The need for more emphasis on an alternative approach to research, which recognizes the value of studies based on historical or philosophical frameworks, has recently been raised in the literature (Crawford, Default and Rudy, 1979; Donaldson and Crowley, 1978; McKay, 1977; Schlotfeldt, 1975).

Crawford, Default and Rudy state (1979, p. 348):

> The urgent task for nursing is to continue to clarify and make more explicit the unique perspective and focus of nursing. Nursing's perspective will be defined by the phenomena it chooses to study..... Currently rather than limit the focus to inductive and deductive scientific research methodology as means to develop knowledge, additional paths to knowledge have to be developed.

The stand taken by Donaldson and Crowley (1978) is that there should be two kinds of research: 1) that which tests theoretically derived hypotheses and 2) that which examines the discipline's structural conceptualizations and values, (ie. research directed toward practical aims that will generate prescriptive theories).

Gilchrist (1971) defined as a need the acceptance of the validity and reliability of research methodology which has as its purpose the generation of theory as opposed to the verification of hypotheses. Field observation is an eminently suitable method in Gilchrist's opinion and is less likely to build research bias into the study than do controlled methods used in gathering experimental data in the laboratory setting. In that clinical nursing research is in its infancy such exploratory studies are needed. This approach to clinical research is supported by Rubin and Erickson (1978) who maintain that observation is an important approach to the development of nursing practice theory. They argue that a dynamic operational field is necessary to observe the subject of enquiry in action. The researcher needs to immerse herself in the clinical material, observing nurses and patients, their facial expressions, posture, body movements and patterns of interaction (Elfert, 1970). If effects of nursing actions are to be observed it is crucial that the contextual field is not altered or distorted in any way. It would appear that there is recognition of the need to try new approaches to nursing research along with continued attention to the use of sound quantitative designs.

In a review of community health nursing research, Highriter (1977) analyzed and categorized 115 studies. Three utilized participant observation, while most utilized survey methods to obtain data. When categorized the greatest number were studies that evaluated services. Included in this category were evaluations of total programmes, performance of techniques and nursing activities and performance in a role. In the studies which evaluated performance effectiveness the two most common indicators used were statistical data on client outcomes and the incidence of detection of patient defects.

Bloch (1975) pointed out the need for a systematic description of the process of giving care in studies designed to evaluate effectiveness, yet Highriter found such descriptions lacking in over one-quarter of the studies she reviewed. In Highriter's opinion, most indicators used were easily quantifiable. However, some studies using physiological measures of patient status raised major questions regarding the validity of the measures employed. Other studies which measured attitude change raised questions of validity in relation to the operational definitions and the conceptual base of the selected tool. This is reminiscent of the criticisms Rosenshine and Furst (1973) levelled at the instruments developed and used to measure classroom behavior. In other studies reviewed by Highriter there were difficulties in establishing adequate control groups. This was related in part to the ethics of withholding treatment from a group if it is believed that such treatment will be beneficial to the clients. This difficulty was evident in a study by Vincent and Price (1977) where the control group was one-third the size of the experimental group as there were enough nurses to provide care for two-thirds of the patients referred to the agency. No attempt was made to obtain groups with comparable characteristics, (the first two arrivals were placed in the treatment group, the next in the control) but in the analysis the groups were compared for similarity in relation to variables that could have affected the findings in this study. Another difficulty in clinical studies has been the need to obtain large enough samples to be able to claim statistical significance.

All the attitude studies reported on by Highriter examined the attitude of the nurse towards selected aspects of her job. No studies looked at attitudes towards clients nor clients' attitudes or opinions about the care they received. It seemed that most studies were concerned with programme success and that success was a function of the number of clients processed rather than quality. Researchers frequently used survey techniques to reach their target population. This is probably a function of two influencing conditions, the length of time involved in interviews, and hence the higher cost over a survey, and the geographic separation of individuals who receive community health services.

From this review it would appear that a study of the nurse's perspectives on client care and her behavior in giving care is an area that has received little study in the past few years. Thus this study will be of value in increasing nursing knowledge. A group of eight nursing studies have been identified that utilized observation to study nurses in the context of care giving. These will now be discussed.

The Use of Observation Techniques in Nursing Research

In addition to the three studies identified by Highriter (1977) in the period she surveyed (1971-1976), five other studies have been located. Four of these collected data in a community setting and one in an institutional setting. In the United Kingdom, Dingwall (1976), Kratz (1975), and Luker (1978) studied the community health nurse or the health visitor. In the United States Mayers (1972) utilized a community context while Soares (178) used observational methods to study the nurse and patient within the context of an intensive care unit. In Canada Cunningham (1978) reported on a series of three studies in which she collected data on the home visit observing the interaction between the nurse and the client.

The Role of Observer

Kratz (1975) investigated the area of the long-term sick in the community. Her focus was on clients who had had a stroke. She selected participant observation as her data gathering method because her purpose in undertaking the study was to develop an understanding of a substantive problem about which she felt she had insufficient information to make _a priori_ decisions on a relevant problem or hypothesis. Kratz mounted a pilot study to assess the feasibility of using participant observation to gather data to describe the role of the nurse in home care. There was some initial resistance by the agency employing the nurses to her proposed approach as it was felt that an observer would alter the relationship between nurse and patient. She reported that her previous experience in community nursing proved to be an asset in establishing her credibility with both nurse and client. Her introduction to clients was that "she was a nurse doing some research". In the situation she took the option of being an observer-as-participant or a participant-as-observer as the situation developed.

Participant observation may be viewed as a definable role, a particular set of techniques or a certain theoretical orientation (Pearsall, 1965). The role itself may be seen as a device for getting information along with a set of behaviors in which the observer himself is involved (Gold, 1969). The intent of such observation is to record the ongoing experience of those observed through their symbolic world (Denzin, 1970). The goal is valid, verified data, analyzed in a manner which is scientifically sound but which respects the right of human beings (Pearsall, 1965).

The master role of observer has several sub-sets from which the researcher may select the one most suited to her needs. Kratz indicated that her choice of participant observation was based on her need to explore the field in an effort to identify the crucial problem. The role of observer can be thought of as falling along a continuum from complete participant to complete observer. In between are the roles of participant-observer and observer-participant (Gold, 1969).

In the observer-as-participant and the participant-as-observer roles, both observer and observed are aware of the nature of the interaction. The observer-as-participant may only have limited contact with those he observes, such contact being limited to one or two interviews. In another instance the observer may avoid taking an active part in the scene being observed, if to do so might change the course of action. Kratz described how on arrival at a home she might talk to the patient about her sewing or the weather, in a participatory manner to put the patient at ease, but she would then take a non-participatory role as the nurse provided care. When the role is primarily that of observer the contact is formalized and brief with no attempt made to ensure any sense of enduring relationship (Denzin, 1970; Pearsall, 1965). This means data will be more superficial than in a study where the role is as participant. Quint (1969) in a study of socialization of juvenile diabetics had to weigh the value of a longitudinal study against the subjects' willingness to be interviewed over a long period of time, the availability of the researcher's time and the added cost. She made the decision to utilize the observer-participant role as the value of the increased data obtained in a longitudinal study was offset by the disadvantages.

An ethnographic study, to be effective, requires in-depth contact with informants. Therefore, in this study the role of participant-as-observer was seen as preferable. Kratz' experience in the home visit suggested that during the nurse-client interaction the researcher's role should be switched to that of observer-as-participant. The decision on the observer role relates in part to the depth of data desired. To identify the nurse's perspectives requires observation over time rather than limited interviews.

Gaining Entry, Establishing Relationships

The problems of gaining entry, establishing relationships, finding informants, and learning the language must all be solved. In Street Corner Society, Whyte (1954) outlined the difficulty he had gaining an entrance to the Italian slum community that he studied. He made several abortive attempts until he was introduced to "Doc", the leader of a street corner group. As a friend of Doc's he was accepted, but only became seen as a member of the group as he was able to converse and act in a manner seen as appropriate to the group. Kratz (1975) noted that her experince as a nurse helped to establish her credibility with the nurses. Pearsall (1965) suggested that while a nurse in the study of nursing has advantages in relation to background knowledge, there is nevertheless a danger of overlooking relevant data because of the familiarity of the context. Kratz encountered another difficulty when she found that notetaking resulted in a breakdown in the relationship she had established with her nurse informants. As she conducted many of her interviews in the car travelling with the nurse between patients even temporary withdrawal for note-taking was difficult. One interesting finding was that, when the observer was introduced as a nurse, the patient tended to see her as forming a group with the nurse. Thus a dyadic rather than a triadic situation was created in which the presence of the observer appeared to be ignored. In certain situations the researcher felt it appropriate to withdraw from the situation, but was generally able to remain within earshot. In those instances the nurse usually volunteered a full account of the interaction once they were out of the patient's home and in the car, so the data could be checked against a corroborative account.

The major difficulty reportedly encountered by being a nurse observer was in checking the perception of a situation with the nurse who had been observed. The nurse did not accept as plausible the fact that the observer might have a different opinion as to what was and what was not valued work (Kratz, 1975).

It would seem that there are both advantages and disadvantages of being a nurse observing nursing. The advantage of being credible to those observed are offset by the danger of overlooking data. The work-situation means that the observer must use field notes as well as tape-recordings to collect data and must be sensitive to the need to withdraw from any given situation if the client appears in need of protection. As Kratz' study was in a similar setting to this proposed study, her findings had implications for this research design. However, the method of participant observation appeared to be feasible providing checks were made on the validity and reliability of both observations and findings.

Finding Informants

Luker (1978) developed a model for assessing the role of the health visitor in geriatric care. The published report deals with the pilot study in which Luker used the observer-as-participant role. The location of the study was selected on the basis of three criteria: willingness of health visitors to be involved in the research; the travelling distance to the researcher's base; and an urban area with health visitors attached to a group of doctors in general practice. The health visitors also had to be visiting the elderly client. In this study the health visitors that participated were volunteers, they were not randomly selected from a population. This has the advantage of decreasing the risk of coercing participants, which is ethically unacceptable, but raises the issue of a possible atypicality of the sample observed. Luker reported that client and health visitor were apparently unperturbed by the presence of an observer even though some topics were discussed which were of a possibly embarrassing nature. She suggested that this may have been due to three factors: students visited regularly with health visitors, so clients were used to a third party; the health visitors selected clients who would not be inhibited by the presence of a third party; topics known to cause embarrassment to some clients were avoided.

Cunningham (1978) reported on three studies which utilized participant observation in a community setting. In all three studies a random sample of nurses in the agency was used, following their selection the nurses were asked if they were willing to participate. The researcher noted that she already knew many of the nurses in the agency and under these circumstances the question is raised as to the degree of freedom that an individual would feel to refuse to take part. This is the only report that clearly identified the way in which client permission to participate was obtained. When the nurse telephoned the client to arrange the visit she asked permission to bring a nurse-researcher with her. On arrival the purpose of the study and the confidentiality of the data were explained to the client. Written permission was then obtained from the client. The observer was in a non-participatory role during the interview which was followed by a structured interview with the nurse.

These two researchers identified two approaches to selection of subjects. On the one hand, by using volunteers Luker ensured that she had co-operative subjects; while on the other hand by using a random sample Cunningham increased the generalizability of her findings. The decision in this research was to use volunteers which will decrease the risk of subject attrition. Cunningham's protocol for client involvement appeared to be ethically sound and was therefore selected as a pattern to follow.

Data Collection

Dingwall (1976) utilized formal and informal interviews, observations of classes, directed conversation and study of documents to analyse the social organization of health visitor training. He collected his data in classes and seminars and in the community health units. His observations were made on students, teachers, and health visitors in the field and he made over 200 home visits with students. The role he adopted was that of an observer-as-participant. His observation of the home visit was validated by an analysis of the student's recording of the visit followed by an interview with the student. He suggested on the basis of his findings that the visit is a loose structure; that data on the client is gathered through questioning, observation, directed conversation and other indirect sources, such as a neighbour. He found that much of what happens looks like a social chat because of the need to let the client contribute ideas. He further observed that there were strong boundaries between the work of individual health visitors that were sanctioned by the concept of privacy. This privacy allowed for variation in practice. The only public area of a health visitor's work is her records. Dingwall recommended that the visit be studied in the future with the focus on the interaction of the nurse and client.

Dingwall utilized the principle of triangulation (Zelditch, 1969) as a means of enhancing the validity of his data. He used a variety of techniques and data sources. He utilized both tape-recordings and field notes to record observed data. Preliminary analysis occurred in the field followed by final analysis when data gathering was completed. This means of enhancing validity by using a variety of data gathering techniques is crucial for any study that utilizes observation as the major research method.

Data Analysis, Theoretical Sampling, and Presentation of Findings

Preliminary data analysis occurs concurrently with data collection in most studies that utilize participant observation. Both Kratz (1975) and Luker (1978) entered the field with the knowledge that there was a problem, but the specific problem emerged as data were collected and analyzed. This contrasts with Cunningham's (1978) approach in which she defined her problem prior to her initial observations and so she had a specific focus on entering as an observer. In a study of the client assessment criteria used by community health nurses Mayers (1972) utilized the data to define categories and then built a model of assessment from these categories. Bruyn (1970, p. 261) gives a list of criteria essential in judging the validity of qualitative data; these include identification of the number of subjects studied, the variety of situations observed, and the extent to which differences in social and individual difference were considered. Mayer's (1972) sample was relatively small: 16 nurses and 37 families were observed. She used the Glaser and Strauss (1967, p. 63) concept of theoretical sampling, which considers the width and diversity of the categories and their saturation in determining sampling adequacy. She considered her sample adequate when no additional data were discovered (i.e. when similar instances kept recurring); when the patients in the sample represented a wide range of cultures, ages, ethnic backgrounds, and problems; and when the nurses who were observed and interviewed reflected a wide range of nursing experience, age and educational background. The boundaries of the categories were not reported.

Soares (1978) utilized Goffman's dramaturgical model to analyse verbal usage in an intensive care unit, employing the participant-as-observer role to gather her data. Her acceptance by the nurses was made relatively easy as she had worked in the unit for a six week period the previous summer, and so she knew the language and was accepted as competent by the group. The analysis utilized the language of the theatre, actor, scene and production to describe the drama and behavior of nurses in the specialized unit. The norms of behavior were described, the importance of language, tone of voice and gesture was then illustrated by the interaction of the nurses in the patient care setting.

In all qualitative studies verification of the findings is dependent on checking two factors, the reliability and validity of a work (Bruyn, 1966). Reliability is based on two assumptions, the first is that the study can be repeated, that is, that another investigator can follow the exact steps of the original procedure. Repetition entails the use of the same categories of study, the same perspectives, the same procedures, and the same criteria of correctness that were originally used. Soares (1973) gave a clear account of the setting, what she observed, the optimal place she found for observation and the analytical categories that she utilized. The second assumption is that it is possible for two or more people to perceive the same meanings by using these categories and procedures. This is more difficult to achieve using one observer and Soares did not indicate whether reliability was tested using a second independent observer.

The validity of the conclusions based on the data is another major concern (Bruyn, 1966). Soares provided a variety of her observations and actual abstracts of dialogue that she recorded on the unit to support her findings. Other methods of validation have been attempted, amongst these the use of quasi-statistical methods by Becker _et al_ is perhaps the most rigorous (Becker, Geer, Hughes and Strauss, 1961). In this study of students in medical school, the researchers collected their data using participant observation. Their choice of method was based on two considerations, the use of a symbolic interaction framework to examine data and the need to find out what was important to students who were in the process of becoming doctors. They viewed medical school as a social system and their interest was in discovering the systematic relationships between simultaneously occurring events in the student's lives. They formed provisional generalizations from initial observations and from these collected data that helped identify the students' perspectives on becoming a doctor. To support their conclusions they coded their data into observer-elicited statements and spontaneous comments from informants. They further classified the data as private (obtained in the presence of the observer alone) or public (obtained in the presence of a group). This information was then presented in extended 2 x 2 tables so readers could judge for themselves the strength of the data. At the same time they utilized analytic induction making explicit efforts to form alternative propositions based on the use of negative case analysis. In this study detailed descriptions were given of the context of the observations. The methodology, the theoretical sampling parameters, and the evolving perspectives were all well described, enhancing accurate replication by other researchers. This study has been described as a classic in the field of participant observation studies (Denzin 1970, p. 215).

The use of theoretical sampling of data appeared to be a legitimate approach for this study. It was crucial to identify the boundaries of the categories and to determine the point of data cut-off. The importance of supporting data in descriptive form was critical when considering the presentation of data and its analysis.

Findings From Studies

The studies by Dingwall (1976) and Luker (1978) both focus on the health visitor. The role and functions of the health visitor and the percentage of time spent in home visiting would seem to be comparable to the community health nurse in the system that will form the setting for this study. A survey by Wilkes and Nimmo (1976) in three different settings (one rural and two urban) showed that the functions of the health visitor were centered, as the name implies, on health promotion. All age groups of the population were served, with most time being spent with the infant and pre-schooler and in geriatrics. In this latter area differences may be found, as a geriatric programme is relatively new in the setting proposed for this study. In the English study 20-30% of the health visitor's time was spent on home visits and 10-20% of time in clinic. Given the similarity of the roles and functions of the two groups findings from studies in the two countries may be comparable.

The findings in Luker's (1978) study indicated that health visitors did not like visiting the elderly because it took too long. Dingwall (1976) had observed that health visitor students also found visiting the elderly took too long and he hypothesized that they did not have an agenda for the visit and that the client therefore took control.

Termination of a visit appears to be difficult when the visit lacks structure. Luker was unable to identify the criteria by which health visitors evaluated their work but she did find health visitors were sensitive to cues from the client. One preliminary finding that Luker planned to pursue further was that health visitors appeared to structure their visits differently depending on the age level of the client. She hypothesized that this may be related to the use of a developmental model. Luker's study showed that non-participant observation is a feasible method of obtaining first hand information on the content and process of home visits. The goal content of health visiting could be identified as well as the place of the elderly in the health visitor's caseload.

Some studies on the health visitor have been motivated by difficulties encountered in establishing evaluation criteria. Hunt (1972), states:

> A good deal is written on what health visitors should do but little on how they should do it, so there is no clear objective standard by which judgment of their work performance can be made. (p. 23).

Dingwall (1976) identified this as a problem in the preparation of students and it appeared to be the impetus behind the study by Mayers (1972). Mayers found that the criteria nurses used to assess clients could be grouped under four main classes: the ease or difficulty with which they gained access to the home; the presence of an open or closed environment; the client's ability or inability to focus on the conversation; and the client's positive or negative mood response. The nurse's assessment of the situation was compared to tape-recordings and the observer's field notes of the visit. Twenty-eight of the 37 families observed were found to have a consistent positive or negative pattern in the four factors that agreed with the nurses' assessment of their coping abilities. Mayers concluded that the criteria could be utilized to make an initial assessment of a situation so that nurses could set priorities within their workload. This was not an elaborate study but it did identify some valid information that can now be tested in a more rigorous fashion. In education one could see if the use of these indicators by students resulted in accurate assessment of client status. This may, in turn, provide useful criteria for evaluation of student effectiveness.

Despite the move to study nursing through observation of the interaction between the nurse and client, or nurse and patient, little attention has been paid to the influence of the organizational structure or the priorities of the nurse herself on her behavior. Dingwall's (1976) study suggested that students are influenced more by the attitudes of nurses in the field than by the values transmitted in the educational system. As educators we need to know what these values are and, more importantly, how they are generated. If both students and practitioners dislike visiting the elderly client can this attitude be changed? To create change one must understand the basic problem and to study the problem its existence must be identified. While a picture of the practice of nursing is beginning to accumulate it is limited. From the realm of "what" is happening, research needs to move a stage further and examine "why" things happen the way they do. The nursing studies reviewed have provided insight into how nurses make decisions, how they behave in given situations, and how they become socialized to their role. The next step is to explore why nurses act in the ways that they have been shown to do, which is the focus of this study.

In a recent article Kilty (1976) raised the question, "Can nursing research learn from educational research?" (p. 97). He quoted an article by Parlett and Hamilton (1972) who pointed out that there have been two fundamental mistakes in educational research: (1) in isolating variables and in studying relationships between variables, research designs have often been clinically 'clean' and as a result remote from the complex realities of educational situations; (2) the results of educational research have been translated into action without consideration of the effect of contextual change on experimental results. These sentiments are supported by other educators. Dunkin and Biddle (1974) have been critical of studies that do not take into account what actually happens in the classroom. Shulman (1977) has emphasized that what teachers do and think is the basic source of information on what teaching is about. Nash (1976) points out that the studies that have been done in the contextual setting have enriched our knowledge of teaching; his concern is with the apparent slowness with which this type of research has become established. Kilty suggests that researchers in nursing should take note of the new generation of educational researchers who have taken into account the forces and influences acting on the individual within the classroom setting and apply their techniques to the study of nursing (Kilty, 1978).

This new breed of educational researcher has drawn heavily on the traditions and techniques of the cultural anthropologist, using ethnography, ethnology and ethnomethodology as methodological approaches to study. The next section of the literature review will examine some educational studies that have used an ethnographic approach and identify their utility for this study.

The Use of Ethnographic Techniques in Education and Their Relevance for Nursing

Ethnography refers to the task of observing and participating in a particular culture over time (Spradley and McCurdy, 1972). In this type of study the researcher as a participant observer is the research instrument (Sanday, 1979). This research results in a wealth of detailed cultural information that forms the basis for understanding society. Ethnography deals with the description of a culture in contrast to ethnology which attempts to classify, compare and explain cultures (Spradley and McCurdy, 1972) and has long been a tool of cultural anthropologists in studies of primitive societies. Today ethnography is being used to study many types of limited populations to determine the ways in which members of a society actively construct their social world. This methodological approach allows members of society to speak for themselves, while the researcher in the role of a participant observer examines complex structures seeking simplification (Van Manen, 1978).

Geertz (1973) speaks of ethnography as "thick description". It is, he says:

> "Our own construction of other peoples construction of what their compatriots are up to" (p. 9).

In that the analysis in ethnography itself is descriptive it tends to disguise the interpretative activity engaged in by the researcher as he sorts out the structures of significance within the data, for the ethnographer is faced with a multiplicity of conceptual structures, which he must grasp and render intelligible to an audience (Geertz, 1973). Thus ethnography is a second order interpretation of the actions and involvements of people with one another, it does not codify, but makes interpretation possible by the use of thick description (Sanday, 1979).

If one believes that the empirical nature of the world is interactionist then the social world is best studied by utilizing a research methodology that examines the interaction as it occurs (Denzin, 1970). Thus the process of participant observation is a commitment to adopt the perspective of those studied, by sharing in their day to day experiences. The intent of the researcher is to record the ongoing experiences of those observed, through their symbolic world. In thick description (Geertz, 1973) the researcher seeks to determine the social meanings and cultural motives that lie at the base of social action (Van Manen, 1978).

It is recognized, however, that human behavior is significantly influenced by the settings in which it occurs. While the study of a specific cultural group resists generalizations to other groups it does allow generalizations to be made within the group. It is the only way one can obtain a true picture of the forces which influence human action so that one can develop theories related to appropriate or expected behavior. Such cultural theory is diagnostic, however, and not predictive in nature (Sanday, 1979). Ethnographic researchers methodically plan the form of data they will collect, the participants with whom they will interact and the questions they will ask (Wilson, 1977); the researcher, however, does not prestructure his inquiries with a priori categories before entering the field.

Ethnographic studies analyze everyday activities that are rational and reportable for all practical purposes. Their domain is that of social phenomena and their purpose is to identify the formal properties of common sense activities (Garfinkel, 1967). Unlike the traditional empiricist the observer must view a culture as the people he observes view it. He sees goals as they see them and not as functions of experimental causes (Bruyn, 1966).

Related Studies in Education

Selected studies were reviewed which used an ethnographic approach to the study of classroom and school behavior of teachers and students. The studies were descriptive in nature and all utilized a sociological or psychological perspective for their analysis.

It would appear that one of the earliest researchers to undertake an ethnographic approach to the study of classroom behavior was G. Alexander Moore, Jr. and his associates (Moore, 1967). A book based on the study described the urban school environment. The data were collected in nine classrooms in three inner city schools and paid particular attention to institutional variables, their effect on school policy and the effect of both on the teacher. School routines were examined in terms of the rights and rituals which constituted the school and classroom routine. Moore compared teachers to anthropologists who enter a new culture with few preconceptions of what the culture contains. The anthropologist attempts to gain acceptance by establishing a bond of friendship with individuals. In the setting studied the culture of students and teachers frequently differed. In fact in all three schools Moore found that children from low income families, whose ethnic backgrounds differed from that of the teacher and the school, found school a perplexing experience. Moore (1971) concluded that teachers must learn the culture of students if they are to teach them. He also suggested that friendship is a major perspective in the urban school.

This study has implications for any occupational group who are providing a service to individuals with different cultural backgrounds. The nurse in the community who sees herself as primarily a teacher may in fact confuse clients if she lacks understanding of their norms and values. Because Moore's study required several observers to collect data, the approach, which used a comparison across classrooms over time, was not feasible for one observer.

A second study used a single observer who collected data through informal conversations with a group of eighth grade girls (Davis, 1972). The researcher used the language of the students to identify their perceptions of school. At the outset Davis used tape-recordings to gather data but found these were distracting and so she used brief field notes, reconstructing the conversations soon after their conclusion. Her study provided descriptive evidence to support a taxonomy of behaviors that showed the relationship between "kids" and teachers to be one of conflict. On the basis of her findings Davis concluded that "kids" saw school as ruining their chances of learning. The pattern of hostility involved "kids" being picked on by teachers and "kids" retaliating by acting up. Davis concluded that teachers - and education - will not change until they listen to the way "kids" think about the institution they share. This is a simple study that used a single observer but provided some well supported findings on the way a particular group of eighth graders think about school. It is only generalizable to other situations with similar contextual variables, but it could be replicated with the methodological descriptions provided. Such a study would be of use in nursing to get at the roots of commonly expressed public dissatisfaction with hospital care. A study based on this design could be utilized in a variety of patient care settings, at relatively little cost, to identify the problem in the client's language.

Another approach in ethnography is the case study of an institution. Warren (1975) focussed on the occupational world of a teacher in all its manifestations. The original basic assumption was that teachers evolve responses to all levels of their occupational experience (ideological, organization and interpersonal) in relative isolation. Isolation was viewed as a function of the discontinuity between an individual's facility in articulating norms and values appropriate to teaching and their inability to make such norms and values operable. The data analysis was organized in terms of the various contexts in which teaching proceeds: the classroom, the school, the school district and the parent community. Data were collected through formal and informal interviews over a three year period, although the bulk of data collection occurred in the first year of the study. Thus this study does fill the ethnological criteria of looking at a society over time. This is in contrast to the previous study (Davis, 1972), that used an ethnographic approach, but lacked the time element necessary for true ethnographic study.

Warren's study identified classroom perspectives of teachers in a school setting and found that the teachers' experience was one of competing voices all of which demanded attention. The reading consultant and the psychologist for example competed for earlier and more frequent referral of students with problems. The relationship between teachers and specialists was one of mutual distrust and mutual dissatisfaction, but communication between the teachers and specialists aimed at clarifying the problems was minimal. The conditions of teaching which teachers accept are important to them. The limit to which they will accept parent participation in the childrens' education, the teachers' willingness to be involved in extra curricular activities and the relationship they are willing to have with students are well guarded prerogatives. Teachers desired a section of a class where students were seen as quick learners and viewed this as a reward, either for long service or for superior teaching. This is because they see their work evaluation as based on student progress. The production of a functioning academic unit is seen as the most compelling obligation that a teacher faces as this is the primary way in which he communicates his academic competency. The final finding is worth noting. While teachers and parents share many values when they both converge on the child as student, their vested interests often conflict and produce tensions not easily resolved through a shared value system. Warren concluded that teachers did indeed work in an isolated situation and that the idealistic values were in conflict with the norms reflected in the context of the classroom.

These findings reflect Dingwall's (1976) concerns on the effects of isolation on the health visitor's level of practice (cf. p. 24). The criteria for performance evaluation are unclear, but most studies which have evaluated community health services looked at the increased attendance at a clinic or the number of individuals treated rather than at the quality of care (cf. p 15). Studies utilizing Warren's approach would obviously add to nursing knowledge in identifying contextual factors which influence the nurse's work. In the community setting the possible effect of organizational policies, consultant physicians and relatives, on the way the nurse practices must be borne in mind.

Another recent use of ethnography has been the single case study approach. A single classroom and a single teacher were studied by Janesick (1977). The purpose of the study was to describe and explain a teacher's classroom perspective. The study described the actions and statements of one sixth grade teacher over a period of seven months. His definitions and criteria of judgements provided evidence for recognizing his perspective as one of creating an effective group and maintaining that group so that classroom goals could be achieved. The researcher used participant observation and interviewing with the teacher, students and other members of the school staff, to gather data so that she could understand how the teacher defined his classroom world and then constructed his actions. As the study was based on the theory of symbolic interaction the researcher examined the process of interpretation used by the teacher. The researcher remained in the classroom environment with the teacher, observing him from many vantage points. Her involvement in classroom activities took a limited form but she interacted freely with the students in informal classroom situations. The observer also participated in some professional activities in which the teacher was involved. Data were recorded by use of both field notes and taped interviews, then analyzed on a weekly basis and interpretations checked with a faculty member to establish reliability and observer objectivity. During the weekly analysis data were examined for patterns, relationships and indices of behavior that would merit further study. This study meets the criteria set out by Spradley and McCurdy (1972, p. 609) for an ethnographic study: it deals with description, it samples a variety of behaviors, it extends over time and has no preset ideas, and utilizes the language of the informant as a basis for study. The classroom perspectives that Janesick identified as central for the teacher she studied were: maintaining a sense of group; focusing on respect in the classroom; planning and organizing the events of the school day; remaining the leader of the group and displaying a style of teaching which reinforced the class goals of respect and cooperation. For the study of community health nurses the case study approach seemed most appropriate as the focus of interest was on the interaction between the nurse and client and the factors that influence this, rather than on the institutional factors that by themselves influence nursing, which may not seem crucial to the nurse in the community. Therefore identifying the perspective of the nurse will direct the focus toward those things that she sees as crucial in her working world.

The problem of descriptive validity is central to approaches to classroom research which is labelled ethnographic and therefore involves the researcher in the role of a participant observer (Erickson, 1978). Janesick (1978) provided rich description to support her observations and described many different occasions on which similar behaviors occurred. This contrasts with a study by Cusick (1977) where he became a member of a class in high school. While he presents data from many situations he tends to generalize from one reported incidence. It is difficult to have confidence in his findings. His interpretation of events tends to be from his point of view, for example he talks of the prestige group of girls as being good looking, but does not offer any evidence that his informants share his view (Cusick, 1973, p. 58). In both studies the social and cultural contexts in which events take place are clearly described and are related to observed actions.

The studies discussed were selected because they utilized ethnographic research for different purposes. The applicability of the method to nursing research was discussed in relation to the type of problems that could be solved. Janesick's approach was seen as relevant for this study. Ways of approaching the methodology in order to capitalize on strengths and weaknesses of the method were examined in relation to specific studies.

Summary

This literature review examined trends in nursing research, with specific emphasis on methodology. It was shown that there is currently a concern for the use of a wide range of approaches to nursing research. Ethnography would appear to be an area that has not yet been utilized, even though the role of a participant observer has been used by several researchers in studying community health and has been found to be a valid approach. Some ethnographic studies utilized in educational research were explored and the types of problems studied suggested the utility of this method for nursing. For this study of nursing in a community setting limitations of time and resources made a case study approach the most feasible. Janesick's (1977) approach to the study of the single teacher was expanded to look at four individuals in a common setting. A comparison across nurses, similar to Moore's (1967) cross-classroom comparison, could then be undertaken. Time constraints prevented the study of the client's perspective. Warren's (1975) findings on the effects of isolation may be related to findings in this study as each nurse's perspective is identified, but the emphasis will be on the nurse within the context rather than on the context as it effects the nurse. This review of literature suggested that there is utility in using an ethnographic approach, in which the researcher takes the role of the observer-as-participant to study the perspective of nursing of four nurses working in a community setting, therefore the approach was adopted for this study. Chapter III presents the design and procedures that were utilized.

CHAPTER 3

METHODOLOGY AND PROCEDURES

Introduction

The purpose of this study was to describe the perspectives of nursing of four nurses in a community health setting and to examine the relationship between their perspectives and their nursing care. In this Chapter the research method will be presented. The implications of symbolic interaction theory for participant observation research will be identified and the procedures used in the study will be presented. The central issues of validity and reliability will be discussed in relation to the study.

Symbolic Interaction

The basic theoretical assumptions of symbolic interaction theory is that a human being has a "self" whereby he defines his situations and makes indications to himself about the meaning of his social reality. Symbolic interaction theory was developed from the works of John Dewey, W.I. Thomas, Charles Hortan Cooley, and George Herbert Mead, amongst others (Blumer, 1969) and makes the proposition that human interaction is mediated by symbols or interpretations. Over time an individual's interpretations come to constitute a perspective, which is a combination of beliefs and behaviours that characterize his definition of a social world. People are born into cultural systems which accept and take certain signs and symbols for granted. Only when conditions lead to the development of situations where our assumptions, which may not be conscious, are no longer adequate will our acceptance of the usual underlying paradigm of human activity be brought into question (Apple, 1971). It is in this social interaction between the self and social reality that the structure of personal meaning develops (Blumer, 1967).

As a person encounters elements of his environment he interprets and gives meaning to them. The individual judges their suitability to his actions and makes decisions on the basis of the judgement. He then constructs the action of his "self" according to those decisions (Blumer, 1969). For example this happens when the individual enters the presence of others; information is sought about the "other" or information already possessed is brought into play. Information sought will include items related to the other person's general socio-economic status, his conception of self, his attitude toward them, his competence and his trustworthiness. Information about the individual helps to define the situation, enabling others to know in advance what to expect of him and what to expect of others. Goffman (1959) refers to this as the biography of the other and such information will guide the way in which individuals act toward one another.

For the interactionist a perspective is a reflective, socially derived interpretation of those things that he encounters. An individual's perspective is a combination of beliefs and behaviour continually modified by social interactions. It involves three components, the set of ideas describing the character of the situation in which action must be taken (the definitions of the situation); the actions or activities engaged in, given the world as it is defined by the individual; and criteria or judgement (Becker, Geer and Hughes, 1968). These components are interactive but can be separated for analytical purposes. Such perspectives form a basis for decisions on which an individual's actions are constructed and the three categories are used in this study in analyzing the data.

Denzin (1978) states that studies, which take as their point of departure the symbolic interactionism of Bruner, need a method that enables the researcher to reflect the unfolding definitions of the subjects themselves. Rich ethnographic description obtained through participant observation would meet the need, as the essential emphasis of participant observations is the systematic description of the social world as it exists for those being studied (McCall & Simons, 1969).

Participant Observation: Implications for Research

In this study an important assumption was that human beings are viewed as rational, and that they are continually involved in giving meaning to their social world. This perspective enables people to make sense of their contacts with others, to interpret their interactions and to construct their actions in accordance with their interpretations. The problem posed in this study was to identify four nurses' perspectives of nursing and to describe and explain their perspectives. In order to do this, enthnography was selected as an appropriate research method, thus the role of the researcher would be that of a participant observer. This role would enable her to catch the process of interpretation in a manner that meets the stipulations of symbolic interaction; that is, catching the process of interpretation by placing and immersing oneself in the social situation being investigated (Denzin, 1978).

Participant observation is a methodology characterized by intense social interaction between the researcher and the subjects in the milieu of the latter (Denzin, 1970, McCall and Simons, 1969). It is virtually impossible to be completely objective in an ethnographic study as selective observation and selective interpretation always work to transform "actual events" into the facts used in a descriptive account. The important thing is that the observer be aware of his selective process as he decides what to observe (Spradley and McCurdy, 1972).

In this study the observer sought to observe the criteria that the informants employed as they interpreted and described their own nursing experience with clients. In the context of this study participant observation is concerned with two aspects of the subjects and their specified situations: 1) describing the process of interpretation used by the subjects in making sense of nursing intervention, and 2) explaining in abstract terms the perspective or definition of the situation the subjects used to explain their actions.

In using participant observation in research it is important that the researcher avoid prestructuring the inquiry to prove or disprove some relationship of variables. While bringing to the field some theoretical ideas pre-structuring inquiry to specific hypotheses is avoided. Extensive notes are taken of the subjects' actions and statements and, where appropriate, activities are recorded for later transcription. The notes are read and the tapes transcribed systematically and as the study progresses themes, concerns and patterns emerge. These patterns may form the basis for hypotheses that require further investigation or verification by the subjects to check their plausibility. The researcher generates tentative hypotheses on a day to day basis as observations proceed and these are then tested as further observations are made. The explanation develops from the descriptive data.

While the generation of ideas, concepts and propositions is ongoing through the study, the major analysis takes place in the post fieldwork stage when the data are interpreted. It is at this point that it is possible to refine hypotheses and examine the conditions under which they hold true. Thus the process of reduction of the data into a manageable model becomes an end goal. Because the participant observer is immersed in the social setting, there is a danger of becoming a sympathizer as one takes on the perspectives of the other participants. Consequently negative examples are purposely sought since they may disprove initial hypothetical constructs. The final aim of the researcher is to achieve an integrated set of propositions, based on a small number of concepts which leads to an increased understanding of a social phenomenon (Denzin, 1970, p. 5). This network of propositions is grounded in the research method but is subject to tests of logical consistency, relevance, adequacy and compatibility with the actions of the participants (Bruyn, 1966; Denzin, 1970). The presentation of the data in narrative form, supported by evidence from statements and behaviours recorded in the notes and interviews, is the culmination of the research process.

Validity and Reliability

A central issue in research that uses participant observation as the method of data collection is the issue of validity of the research. The whole aim of such research is a valid interpretation of the world as perceived by its inhabitants.

It is acknowledged that qualitative research deals with subjective data, in that the researcher, the subject and his or her preconceived ideas about nursing are revealed. On the other hand, subjectivity is also used to refer to the quality of evidence, indicating data that are unreliable or biased. Similarly objective research focusses on the object under study: (the classroom, the materials or the administrative structure) but the term may also be used to indicate that a study is objective, reliable and factual (Scriven, 1972). It is important to recognize these alternative definitions in order to understand that a subjective study, that is one that focusses on the perceptions of the subjects, can be objective in its presentation of reliable and factual data.

To ensure validity of data Bruyn (1966, p. 255) stresses that what the researcher says is reality in the minds of those he studies, must be the same reality as conceived by the subjects, not reality as interpreted by the researcher. If Homan's (1955) criteria of adequacy are utilized in collecting data and selecting examples for presentation the likelihood of a valid interpretation is increased. The criteria outlined by Homans speak to adequacy in relation to time, place, social circumstances, language, intimacy and consensus.

(1)	Time	The more time spent with a group the greater the chance of obtaining an accurate interpretation of the social meaning of the group to the members.
(2)	Place	The closer the observer works with the people he studies the more accurate should be his interpretation of the social situation.
(3)	Social Circumstance	The more varied the activities witnessed by the observer the greater the accuracy of the interpretations.
(4)	Language	The more familiar the observer is with the language of the participants the greater the accuracy of the interpretations.
(5)	Intimacy	The greater the degree of intimacy established by the observer with the subjects the greater the accuracy of the interpretations.
(6)	Consensus	The more the observer confirms the expressed meanings of the subjects the greater the accuracy of the interpretations.

McCutcheon (1978) outlines three criteria that provide evidence of internal coherence in an ethnographic study and suggests these can be used by the reader to judge the validity of the study. The first is that there must be sufficient evidence both in terms of quality and quantity, to support the researcher's interpretation. Second, the interpretation must be shown to be probable, given a knowledge of similar situations. Finally, the interpretation must be useful in helping understand the subjects under study.

Because description and explanation have a first person quality other studies lack, validity is a central issue in qualitative studies, whereas reliability is central to the quantitative study in which sampling adequacy and statistical concerns are central issues in study design. It is recognized that reliability is an issue more appropriately considered in relation to the quantitative paradigm. In fact reliability is more pertinent to quantitative studies (McCutcheon, 1978) than to qualitative studies that have no prestructured categories prior to research; such categories emerge from the data. The focus of qualitative research is a valid representation of what is occurring acquired not at the expense of reliable measurement, but rather without allowing reliability to determine the nature of the data. Nevertheless the goal of high reliability and high validity is essential to all research. It is the degree of emphasis that differs in the two paradigms.

The Setting

The setting for the study was a community health clinic in a metropolitan area with a total population of just over 500,000 people. The city health service is divided into nine regions each of which is organized around a clinic. The service is under the jurisdiction of a local board of health which sets the policies and the programmes on a city wide basis. Each clinic has a nursing and dental division and a speech therapist. A physician and nutritionist provided consultation at the clinic on a regular basis. Some clinics have the services of a nurse consultant prepared in mental health and there is a mental health division for client referral or nurse consultation. The nurses at the clinics serve on a variety of health programme committees at the city level and have input into the planning and implementation of the nursing programmes. As well as the nurses working in the clinics there is a group attached to the home care division, which is a jointly run division in the city social services department (Figure 3.1).

While overall administrative responsibility is vested in the medical officer for the city, there is a director and assistant director of nursing who are responsible for the nursing services. There are also two nursing supervisors, one of whom is responsible for pre-school services, the other for communicable disease control. Within each clinic there is a regional nursing supervisor, whose role is administrative and two charge nurses, one for well baby care and one responsible for the immunization programme (Figure 3.2). The region served by each clinic is further subdivided into districts and a nurse is assigned to each district. The majority of nurses hold a baccalaureate degree in nursing. The remainder are either registered nurses without further preparation, or nurses who have obtained a diploma in public health nursing. The district nurses were responsible for all school health in their area and they also undertook home visits. As well they also worked in the clinic a certain number of afternoons a week and served as liaison on programme committees or with other city or community agencies.

The programmes provided by nurses are family health, birth control, and communicable disease control. Family health includes prenatal, infant and pre-school (including kindergarten), adult health and geriatric health programmes. The birth control programme includes provision for birth control measures and family planning education. The communicable disease programme includes immunization, tuberculosis follow up and communicable disease etiology (Mills, 1979). Clients are generally seen in one of three settings, the clinic itself, the school or at home.

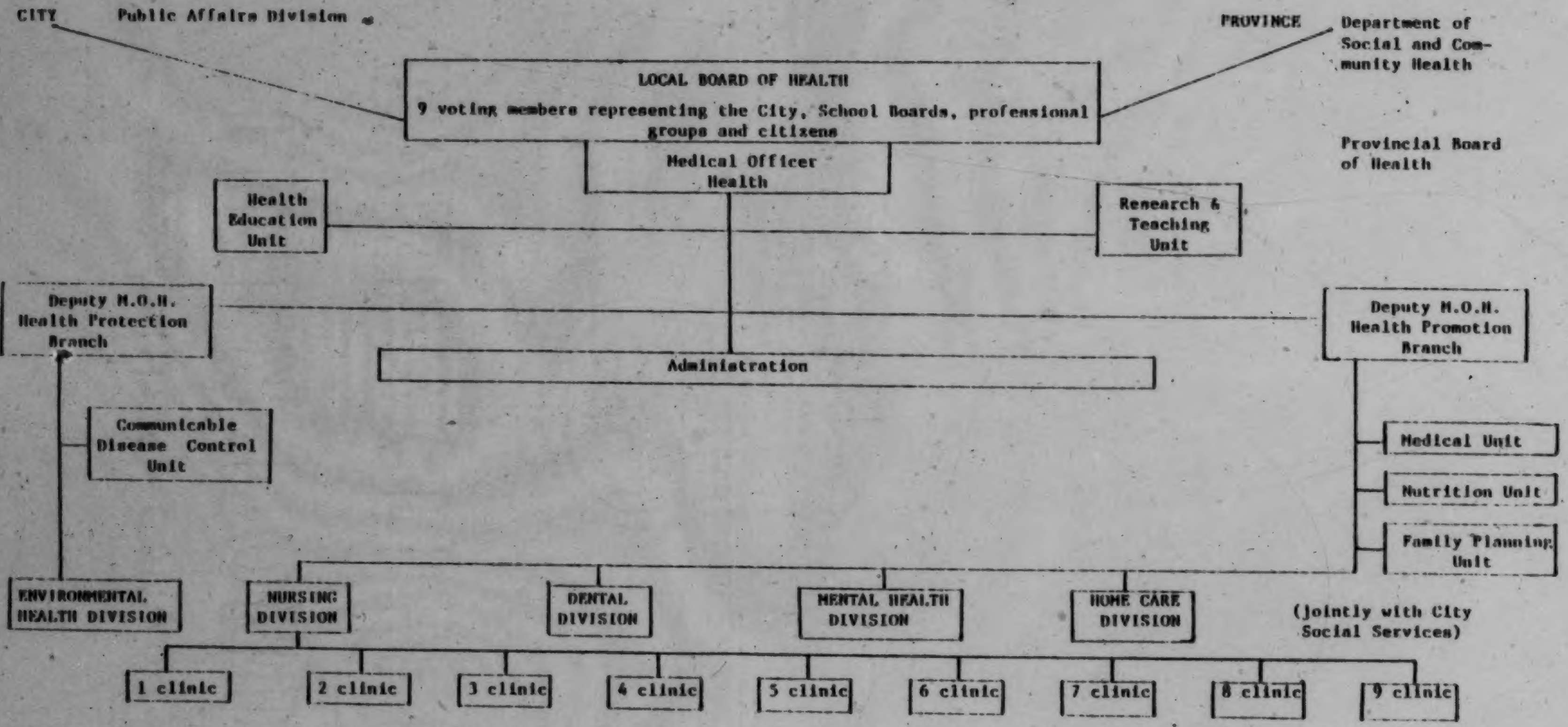
CITY
Public Affairs Division
PROVINCE
Department of Social and Community Health
Provincial Board of Health
LOCAL BOARD OF HEALTH
9 voting members representing the City, School Boards, professional groups and citizens
Medical Officer Health
Health Education Unit
Research & Teaching Unit
Deputy M.O.H. Health Protection Branch
Deputy M.O.H. Health Promotion Branch
Administration
Communicable Disease Control Unit
Medical Unit
Nutrition Unit
Family Planning Unit
ENVIRONMENTAL HEALTH DIVISION
NURSING DIVISION
DENTAL DIVISION
MENTAL HEALTH DIVISION
HOME CARE DIVISION
(jointly with City Social Services)
1 clinic
2 clinic
3 clinic
4 clinic
5 clinic
6 clinic
7 clinic
8 clinic
9 clinic

FIGURE 3.1

ORGANIZATION OF THE LOCAL BOARD OF HEALTH AND HEALTH DEPARTMENT

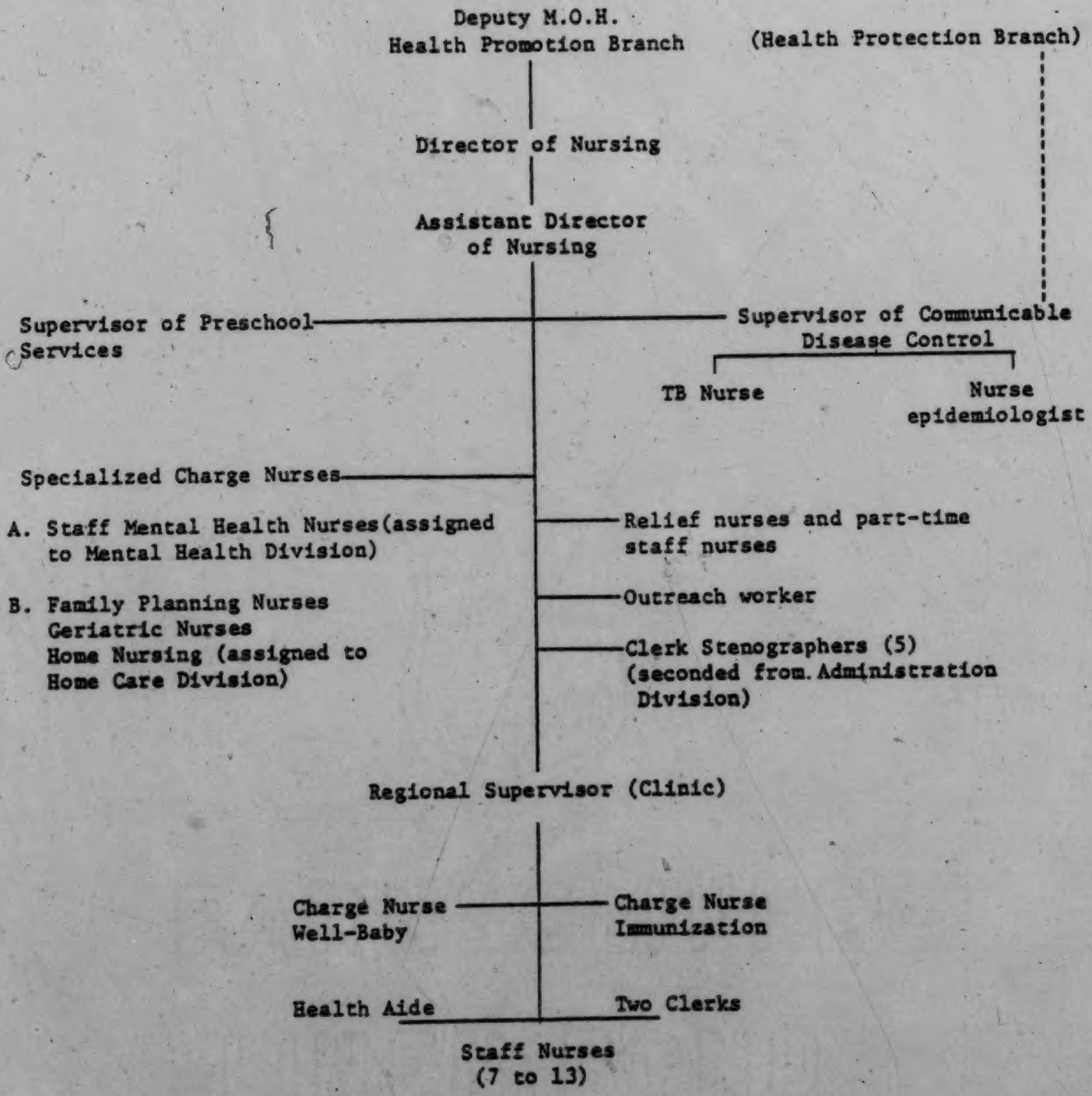
Deputy M.O.H.
Health Promotion Branch
(Health Protection Branch)
Director of Nursing
Assistant Director of Nursing
Supervisor of Preschool Services
Supervisor of Communicable Disease Control
TB Nurse
Nurse epidemiologist
Specialized Charge Nurses
A. Staff Mental Health Nurses(assigned to Mental Health Division)
B. Family Planning Nurses
Geriatric Nurses
Home Nursing (assigned to Home Care Division)
Relief nurses and part-time staff nurses
Outreach worker
Clerk Stenographers (5) (seconded from. Administration Division)
Regional Supervisor (Clinic)
Charge Nurse Well-Baby
Charge Nurse Immunization
Health Aide
Two Clerks
Staff Nurses (7 to 13)

FIGURE 3.2

ORGANIZATION OF THE NURSING DIVISION
LOCAL BOARD OF HEALTH

The setting for this study was initially one community health clinic within this city system. It served a mixed socio-economic group in which lower-income families tended to predominate and in which there was a high proportion of transient families. The clinic had a supervisor, two head nurses and nine district nurses. There was also a nurse attached to the clinic who had had additional mental health preparation and who was available to the other nurses as a consultant. During the course of the study one of the subjects was promoted to an assistant supervisor's position and was moved to another clnic. The researcher was able to follow her in the new setting.

Selection of Major Informants

The major informants were four nurses with baccalaureate degrees who volunteered for the research project. No other presage or context variables were considered when obtaining the volunteers. The main factor considered was the individual's willingness to cooperate with the researcher over a prolonged period of time. The informants therefore constituted a sample of convenience. Each informant was observed intensively, as she nursed her clients, for a minimum of fifteen days, spread over a five month period. The observations commenced at the end of September and terminated at the end of February. During most of the five months peripheral involvement was continued with all informants. The exception was a two week period in January when all nurses in the clinic were involved in a two week group dynamics workshop. At this time the observer was not involved as a participant.

The Method of This Study

The method of gaining entrance to the situation, gaining informants, establishing credibility and explaining the study to participants are all important dimensions in the success of a study of this nature (Whyte, 1955). In this study entry had to be negotiated at two levels, the health agency and the local clinic.

Negotiating Entry and Obtaining Volunteers

An initial request to undertake the study was submitted to the medical officer of health. This was followed by a meeting with the director of nursing and her assistant. A meeting was arranged with the supervisors of all clinics where the interest in studying community health nurses in their daily working situations was explained. The following week the researcher spoke at an educational meeting for all nurses in the city health service and discussed a previous study on community health nurses which she had completed. This was done in an attempt to help the nurses better understand the proposed research. Following the presentation a request was made for volunteers. Two clinics were required, one for the pilot study and one for the main study. Within a two week period two clinics had volunteered. In one clinic only three nurses were willing to participate, and so it was selected for the pilot study. In the second clinic five nurses had volunteered, so it was selected as the "study clinic", one nurse transferred from this clinic prior to the onset of the study.

Pilot Study

During the month of July a pilot study was conducted. The purposes of the study were:

1. To acquaint the researcher with the range of nursing services offered in an urban community public health clinic.
2. To test the feasibility of the observer role and the proposed data gathering techniques.

Presentation of Research

Three nurses were involved in the pilot study. One was utilized to develop an understanding of the normal work pattern of the nurse, while the other two were used to test the data gathering techniques.

The purpose of the study and the researcher's role as an observer were explained to all staff at the weekly meeting. At this time the researcher asked if she might interview all nurses to get a general idea of their concepts of community health nursing. All made appointments within the next forty-eight hours without further prompting. They continued to provide input and answer questions during the rest of the pilot study period. The reception of the researcher was positive and suggested that there would be no problems with entry into the "study" clinic. The two nurses used to test the data gathering techniques were told that the observer would not provide nursing care but would interact with clients in a social manner.

Introduction to Clients

Instruction was given to the nurses on the introduction of the research to clients. When the nurse called to make an appointment for a home visit they asked the client if they might bring a nurse-researcher to observe the visit. On arrival the researcher explained the purpose of the visit and asked for a written consent to tape the session (Appendix A). It was found that obtaining a written consent at the outset of the visit interfered with the nurse's visit. It was decided, therefore to tell the client that a written consent would be obtained, but to leave it until the end of the visit. In the clinic consent was obtained while the client waited to see the nurse.

Observation and Tape-Recording

No client objected to either observations of the visit or its tape-recording. The nurses were reluctant to take the observer on some visits if a tape-recorder was to be utilized, but were willing if the visit was not to be taped. It was understood by the nurse that notes would be made in place of recordings. The nurses stated that in bereavement visits or in some cases of communicable disease follow-up entry was difficult and they felt the client would refuse to see them if a tape-recorder was used. The decision was made not to press the nurse but to accept the limitation of taking notes on the interaction.

In the observed interviews the client was assured that the data would be confidential and that while excerpts of conversation might be used, no names would be divulged. One client had been somewhat apprehensive prior to this assurance, but on being told that no information would be used that could identify her she said she would be happy to co-operate. In one instance where the researcher omitted the explanation the nurse provided it as she was terminating her visit. This suggested that the nurse felt some commitment to the project.

Once the tape-recorder was set-up it did not appear to interfere with the dialogue in that sensitive matters, such as birth control were fully discussed. The observer sat out of the direct line of sight of the nurse and client. The nurse was more aware of her presence than was the client and on occasion she would verify with the observer a response she had made to the client. The observer felt a brief and concise answer to the nurse's question was required in order to maintain her credibility. This approach was utilized in the study.

Interview with Nurses and Client

The original interview guide used to gather initial information was found to be too specific. The responses were channelled to the researcher's interest (e.g. the role of administrative policy in decisions) rather than the nurse's concerns (e.g. lack of time). A less structured questionnaire was prepared (Appendix B) and resulted in a more open flow of information. One nurse complained of the lack of structure but her responses proved satisfactory. The form of question to be put to the subjects in a further interview, based on elements identified from the initial data was drafted (Appendix C).

Four follow-up visits were made to clients to check the reliability of the observations of the nurse-client visit. These proved to be time consuming and difficult to arrange. The decision was made not to make regular follow-up visits to clients in the study proper.

Presentation of the Study

Nurses

The nurses in the clinic met with the researcher one week before the data gathering commenced and the purpose of the study was explained in general terms. The nurses were told that the researcher wanted to develop an understanding of what it meant to them to be a community health nurse and of their experience of being a nurse. The observer's role in the clinic was clarified and her presence at meetings and inservice sessions agreed to by all the nurses. Permission to interview all the clinic's nurses was sought. Following the initial meeting the four remaining volunteers met with the researcher individually and the extent of involvement of the subjects in the research and the time commitment required was clarified. The confidentiality of the data was discussed at this time, the four nurses being assured that their names would not be used in the study. They were given the chance to withdraw if they felt that they no longer wished to participate and were also told that they had the right to withdraw at any time during the study if they wished to do so.

Clients

The involvement of clients raised the ethical issue of informed consent. In home visits, whenever possible, the nurse asked the client if she could bring a nurse-researcher with her on the visit. However, many clients did not have telephones, and for some English was a second langage, and so communication was easier on a face-to-face basis. In these situations an explanation was given to the client on arrival at the home. The client was asked if he/she minded if the researcher observed the session. An explanation was then given that the researcher was doing a study of community health nurses and of their work with clients. Permission was then sought to tape the session and a written consent was obtained (Appendix A). In the clinic situation the researcher approached the client when he/she entered the nurse's office and the same procedure regarding explanation and consent was followed as in the home visit. If the client's command of English was not considered sufficient to obtain an informed consent, the interview with the nurse was not taped. In some cases the client declined to have the interview taped but consented to the observer being present and taking notes.

Entering the Field

The researcher spent a week in the unit prior to formal data gathering. This period was used to get the subjects used to the observer accompanying them and to having visits tape-recorded. During this period the observer engaged in all activities planned for the data gathering period. The researcher became familiar with the conversational patterns and normal behaviour of the nurses during this period. The organizaton of the working week and the social interaction patterns within the clinic, as well as the informal leaders, were identified. This week was critical to the researcher as she sought acceptance by the staff in the clinic and established her role.

Process of Data Gathering

Data were gathered by the use of observation, tape recordings, formal and informal interviews and a study of the nurses' written records on the clients. More than one approach to data collection was used to help confirm the validity of observations (Zelditch, 1969).

Two types of files were set up. In the "mundane" files names of clients, types of visits observed, and the source of data (e.g. field notes or tape) were recorded. "Analytic" files were established which consisted of raw data, tentative hypotheses, preliminary categorization, and tentative schemes for further analysis (Lofland, 1971).

The Observer's Role

In this study the researcher took the role of participant-as-observer (Gold, 1969, cf p. 18). In this role the researcher identified the purpose of her presence in the clinic with all staff members and set the limits for client interaction with the four subjects. In the course of a day the researcher shared in the activities and entered into interaction with other staff members in the clinic. In the nurse-client visits the researcher used the observer-as-participant role. The researcher engaged in initial social interaction with the client but took no part in the nurse-client interview unless invited to do so by either nurse or client.

The four subjects were observed in as many situations as possible. The reseacher attended meetings, both inside and outside the clinic and took part in the social activities organized by the staff. The subjects were observed on home visits, in schools and in the clinic setting working with clients. The fact the observer was a nurse was established with the client. This was done because of the experiences of Luker (1978) and Kratz (1975).

The nurses understood that the observer was a participant primarily for research purposes, thus rationale for the nurses' actions could be sought on a continuing basis. The role also encouraged the nurses to provide unsolicited information and this frequently occurred at coffee breaks or over lunch or in casual meetings in the hallways of the clinic. These casual contacts were particularly useful when the target for observation for that week was one of the other informants. In this way evidence from all nurses was constantly being collected over the full study period. The role of observer also allowed the researcher to withdraw from a situation at her discretion without reneging on any obligation of the agency (Lutz and Iannocome, 1969).

In order to avoid becoming too deeply involved in the clinic the observer withdrew from the situation for a week at the end of the October and the November-December data collection periods. Also a group dynamics workshop, which occurred in mid-January and lasted two weeks, in which the researcher did not participate, allowed a further period of disengagement. This helped to prevent the danger of "going native" that is a risk when one takes the part of a participant-as-observer (Gold, 1972).

Tape Recordings

All formal interviews with the subjects were taped as were many of the observed nurse-client interviews. An Audiotronic 148A tape-recorder was used that had an excellent pick-up to six feet from the source of the conversation. In play it was unobtrusive and it did not appear to be disruptive to nurse-client interaction. One difficulty was the amount of background noise in the clinic setting, which made transcription difficult at times.

The nurse-client visits were transcribed by the researcher. This approach had the advantage of allowing observed non-verbal behaviour to be inserted as the transcribing took place. It was also helpful in reviewing the interaction that occurred in the interview between the nurse and client as part of the preliminary analysis.

Field Notes

Field notes consisted of jottings of salient points that were reworked later the same day. These took the form of reconstructions of the visit or of short conversational excerpts. Non-verbal behaviour was also noted in conjunction with taped nurse-client interviews. The notes recorded during an interaction were kept brief so that the observer could concentrate on what was happening in order to get the feeling for the situation as well as the verbal exchange. Field notes were also used to identify beginning ideas on relationships (within the data) which then provided a beginning cross check for later analysis.

A loose-leaf notebook 11" x 7" was found to be the easiest method for recording field notes. It was easily portable, and it was relatively unobtrusive in use. The notes for each nurse could be filed directly in a master file. Dating pages was of more value than numbering them in keeping track of observations. A second notebook, with pockets, was used for consents, client information sheets, nurses activity sheets and interview schedules.

Interviews

Four formal interviews were held with each nurse. For the first two interviews a standardized guide was utilized (Appendix B and Appendix C). For the third interview an individual guide was developed for each nurse, although some common questions were included (Appendix D1-D4). The first interview was given before the nurses were observed with clients. The second and third interviews were given at the conclusion of the respective observation periods and prior to the withdrawal periods in October and December. Interview four was unstructured, it followed the presentation to the nurses of the individual case studies. The purpose was to check the researcher's interpretation of the nurse's perspectives with them so that incongruencies in interpretation could be clarified.

A brief interview was also conducted following each nurse-client interaction to determine what the nurse had viewed as important in each situation (Appendix E). The written evaluation on the client's record was compared to the verbal evaluation.

All nurses in the clinic were interviewed using the first standardized guide (Appendix B). Their perspective of nursing and perceived priorities in pubic health nursing were obtained.

Informal interviews were frequently used to follow-up the nurses' continued activities with clients or to clarify observations that were unclear (Appendix F). Conversations with other nurses to which the observer was privy also created a need for clarifying information obtained.

Written Records

In clinic there were a variety of records kept by the nurse. Client visits to the clinic were charted on a cumulative record that was filed in the clinic. A similar record, used on school-age children, was filed in individual schools. Post-partum visits were recorded on the back of the official birth notice received at the clinic and these were later attached to the clinic record when a parent brought her child for a first visit. There were no family rosters and home visits (other than post-partum, or those requiring a formal report, such as tuberculosis follow-up) were recorded by the nurses for their own use only. The nurses provided these notes for the researcher on request. Following a visit the nurse's notes were recorded by the researcher on the back of the client data sheets.

Nurse's Work Sheets

The researcher also kept track of the types of activity the nurses engaged in during the course of a week's observation. These activities were recorded on a standard form (Appendix G) and could be used for comparison with each nurse's perception of a working day elicited in the initial interview.

Theoretical Sampling

Theoretical sampling refers to the amount of data collected on the categories identified within the total data. Adequate theoretical sampling is judged on the basis of how widely and diversely the analyst chooses his groups for saturating categories. This is in contrast with an adequate statistical sample, which is judged on the basis of the techniques of random sampling in relation to the social structure of the group, or groups, sampled (Glaser and Strauss, 1967).

In this study each nurse was observed for a minimum of twelve client visits in clinic. These visits covered adults, who were either being immunized or receiving influenza vaccine, and infants and pre-schoolers. Babies and pre-school children are scheduled to attend the clinic at regular intervals. Each nurse was observed at least once with a two, four and six month old client, a child of either one year or eighteen months of age (immunization) and a three year old (developmental testing). One unscheduled visit, where the mother presented herself with a problem with the child, was also observed for each nurse.

A minimum of four home visits per nurse were observed. For each nurse these included communicable disease visits and post-partum visit. Additional visits were observed for individual nurses and these included follow-up of school problems, assessment of the need for home-care services, assessment of the need for dental assistance and follow-up of mothers and newborns considered to be "at risk".

A minimum of eight nurse client interactions were observed in the schools. All nurses were observed in health teaching situations and giving first aid. Additional activities observed were immunization, head combing and vision screening. Nurse-teacher contacts were also observed for each nurse. Two of the four nurses were also observed teaching in the classroom; the other two did not undertake any teaching during the observation period.

Each nurse was observed teaching an adult group although the situations varied. Prenatal classes, orientation of student nurses to community health, first aid for teachers, and orientation of post-partum mothers to community health services were among the varied situations. All four nurses were also observed participating on committees, both inside and outside the clinic, and in nursing meetings.

Informal observations included interaction in the lunchroom, in the nurses' room or in social settings. Problems with clients were discussed with other nurses during social contacts and advice on working with a particular family or client might be solicited. Consultations with colleagues were necessary if a family had children in more than one school and if there was a different nurse assigned to each school. Informal observations were therefore important in developing an overall view of the nurses' perspectives.

At the end of the observation period no new categories of client or new situations were being identified by the researcher. While some emergency situations did occur, such as investigation of child battering, they did not occur when the researcher was available to go out with a specific nurse, but they were discussed by the nurse on her return. All regularly recurring situations were observed during the five month period.

Data Analysis

Initial Phase of Data Analysis

In the initial phase of analysis the researcher defined, from the nurses' perspectives, the problems, the concepts and the indices. At this stage data analysis was undertaken on a daily basis. Field notes were read, looking for significant incidents, conflict situations, patterns of behaviour and frequently recurring actions and statements of the nurse. This resulted in the generation of tentative hypotheses which provided the basis for further observation and interviews.

Two outsiders to the study were asked to read the interviews and field notes and their impressions were used as a check against the researcher's interpretation (Spradley and McCurdy, 1972). Both these outsiders were nurses. One has a Ph.D. in adult education and had been a practicing public health nurse, the second has a Ph.D. with a major in counselling and teaches psychiatric nursing.

The symbolic interaction framework was utilized throughout the analysis to provide direction. This meant that the researcher defined the situation by examining the manner in which the subjects defined their situation. The following questions were considered throughout the analysis.

1. How do the actors define their settings?
2. What is the process by which the definitions develop and change?
3. What is the relationship between the actors' perspective and their behaviour?

Table 3.1 shows the relationship of the research questions, to the framework, the data gathering and the analysis.

Tenative Model Building

At the tentative model building stage the frequency and distribution of individual findings were checked to examine the interrelationships in the data. The referents for model building were the exploratory research questions for this study. These were related to the nurse's statements and actions and the descriptions of the interactions with clients during home, school and clinic visits. Conflict situations were also recorded

Table 3.1

The Relationship of the Research Questions to the Dimensions of Perspectives, Symbolic Interaction, Major Data Gathering Techniques and Data Analysis

Research Questions	Dimension of Perspectives	Dimension of Symbolic Interaction[a]	Major Data Gathering Techniques	Data Analysis
1. Elements of Perspective	Ideas about nursing	Definition of setting	Initial Interview (Appendix B) Informal Conversations/Observations Second Interview (Appendix C)	Listing incidents Generating tentative propositions
2. Contextual Variations which influence the perspective	Ideas, Actions, Judgements	Process by which definitions develop and change Relationship between perspective and behaviour	Formal Interviews Nurse-Client Observations Post-Visit Interviews (Appendix E) Informal Conversations/Observations	Listing Incidents Confirming or disproving propositions Developing categories Model building
3. Assumptions about nursing and clients	Ideas, Actions, Judgements	Process by which definitions develop and change Relationship between perspective and behaviour	Second and Third Interviews (Appendix D) Nurse-Client Observation Post-Visit Interview Informal Conversations/Observations	Listing incidents Confirming or disproving propositions Developing categories Model building
4. Synthesizing Information into Perspective	Judgements	Process by which definitions develop and change Relationship between perspective and behaviour	Formal Interviews Informal Conversation/Observations Nurse's Records	Listing incidents Developing categories Model building

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[a] The Relationship between the actor's behaviour and her perspective is observed as the nurse nurses the client, and as she interacts with her colleagues.

for each of the major informants. Categories were developed representative of these incidents.

Re-Analysis on Completion of Field Work

Five months of field work produced over eight hundred typewritten pages of notes. The data that were included in the description were that which was judged to be representative of the most substantive and revealing information given the purpose of the study, to identify the meaning of nursing to the nurses. Each nurse's perspective and her approach to nursing was presented in the form of a case study. Following completion of the case studies the perspectives were re-examined to discover if relationships amongst the four nurses' perspectives along the dimensions of ideas, actions and judgement existed. The individual perspectives were compared for trends evident across the four subjects and these findings were compared with appropriate literature.

The findings are present as the perspectives of four practitioners of nursing in a community setting and should be interpreted in the context of that setting. In Chapter 4 the contexts within which the four nurses nurse is described: the community, the clinic setting, the peer group and the educational programmes common to all four nurses.

CHAPTER 4

THE SETTING

The setting differs somewhat for each nurse in that, while they all work out of a single clinic they are responsible for different districts within the area serviced by the clinic. In this chapter the major characteristics of the setting and the beliefs about nursing held by colleagues of the major informants, will be described.

Characteristics of the Setting

Greenfield Clinic[1] is situated in a city with a population of 425,090.[2] The population in the area served by the clinic is approximately 45,587 people.[3] The population has almost equal representation of men and women, the modal age of the population is 20 - 34 years (29.4% of the population). Over one quarter of the population have less than a Grade XII education and there are relatively few people (3.1%) with university education. Therefore one can assume

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1. In the narrative the names of places and persons have been changed, where necessary to ensure anonymity.

2. Unless otherwise specified, the statistics used in this section are taken from Statistics Canada, 1976 Census of Canada. Ottawa: Queen's Printer, 1978.

3. Information supplied by the Supervisor of "Greenfield" Clinic. The number was based on the 1976 Census, with estimates added for the newly developed areas.

that incomes in the area are relatively low and the most common occupations for men are construction and trades (20%), service occupations (13.1%) and sales (10.6%). Clerical and service occupations are the most common occupations for females. Over 15% of the families have only one parent in the home but the census does not identify the sex of the parent. The area is known for the high turnover of the population; in some schools the turnover of students in one year is over 50% of the school population.[4] There is a wide ethnic mix in the population and for many of these citizens English is a second language with German, Italian and Ukrainian as the most common first languages. Since the last census in 1976 a large, low income housing development has been built in the north-east end of the area, which has increased the single parent and Canadian native segments of this population.

Greenfield Clinic

The clinic itself is a self-contained building fronting onto a wide street. There is adequate on-street parking for clients, and bus services pass within one block of the clinic. Consequently one can assume reasonable ease of access for the clientele for whom the services were designed. To the East of the clinic are two districts where high density, low income housing predominates. Many of the clients in these district do not have cars, and had difficulty reaching the main clinic with small children, so a satellite clinic, Richmond, was set up. This clinic is situated in a shopping centre and is open one full day a week. In the main clinic clients are seen by appointment on Monday, Tuesday, Thursday and Friday afternoons.

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[4] Information supplied by school principal, Shipton School.

Within the clinic there are four groups of health care workers, the nurses and their clerical help, the dental hygienists and their clerical help, the two health inspectors and a speech therapist. A mental health nurse, is available two days a week, both to see clients and to act as a consultant to the nurses. Her services and those of a physician are shared by a second clinic. The city family planning division is also available for consultation.

At the onset of the study the nursing staff consisted of a supervisor, one nurse whose primary responsibility was infant and pre-school services, one nurse whose responsibility was primarily immunization and nine district nurses. The infant and preschool nurse was not assigned to schools but visited new babies who were classifed at risk throughout the area served by the clinic. The immunization nurse had no district but was responsible for two small schools. In December the immunization nurse retired and the position was changed to that of Assistant-Supervisor. All district nurses spent one or two half-days per week in seeing clients in either the main or the satellite clinics.

The floor plan of the clinic is shown in Figure 4.1. The clients enter through the main door and turn right into the main reception and waiting area. Four interview rooms are on the right hand side of the clinic. The dental hygienists have two examining rooms at the end of the waiting area. To the left of the entrance hall is a second corridor. This section of the clinic houses the health inspectors, the nursing supervisor, the speech therapist, an office shared by the medical officer and the mental health consultant, and the nurses' room. The nurses' room has a work bench on two sides with an open storage area above. This is where the nurses keep their reference materials, client information, personal books, etc. There is a telephone in the corner for contacting clients. Under the window is a large book case filled with reference books and materials for the nurses' use. A round conference table holds current articles and a book for new policies. Current material is kept on the table for a two week period and is then filed.

At the end of the entrance hall is the boiler room and the kitchen. The kitchen is the social area for all staff in the clinic. The staff meet for morning coffee, lunch and an afternoon break. Depending on their workload for the day most of the nurses generally come to the clinic first thing in the morning and talk with each other before going out to their districts. It is usually not feasible to make home visits before 9:30 a.m., at the earliest, and so the early morning is often used to write up records and reports, to contact clients to arrange a visit, or to follow-up a problem identifed in a school the previous day. Individual members of the clinic staff frequently provide cakes or cookies to go with the morning coffee and the feeling one gets in the social area is of a friendly outgoing group.

The clinic can thus be said to be divided into work and social areas. The work area is further divided into a public and a private area, the latter being normally accessible to clinic staff but not to clients.

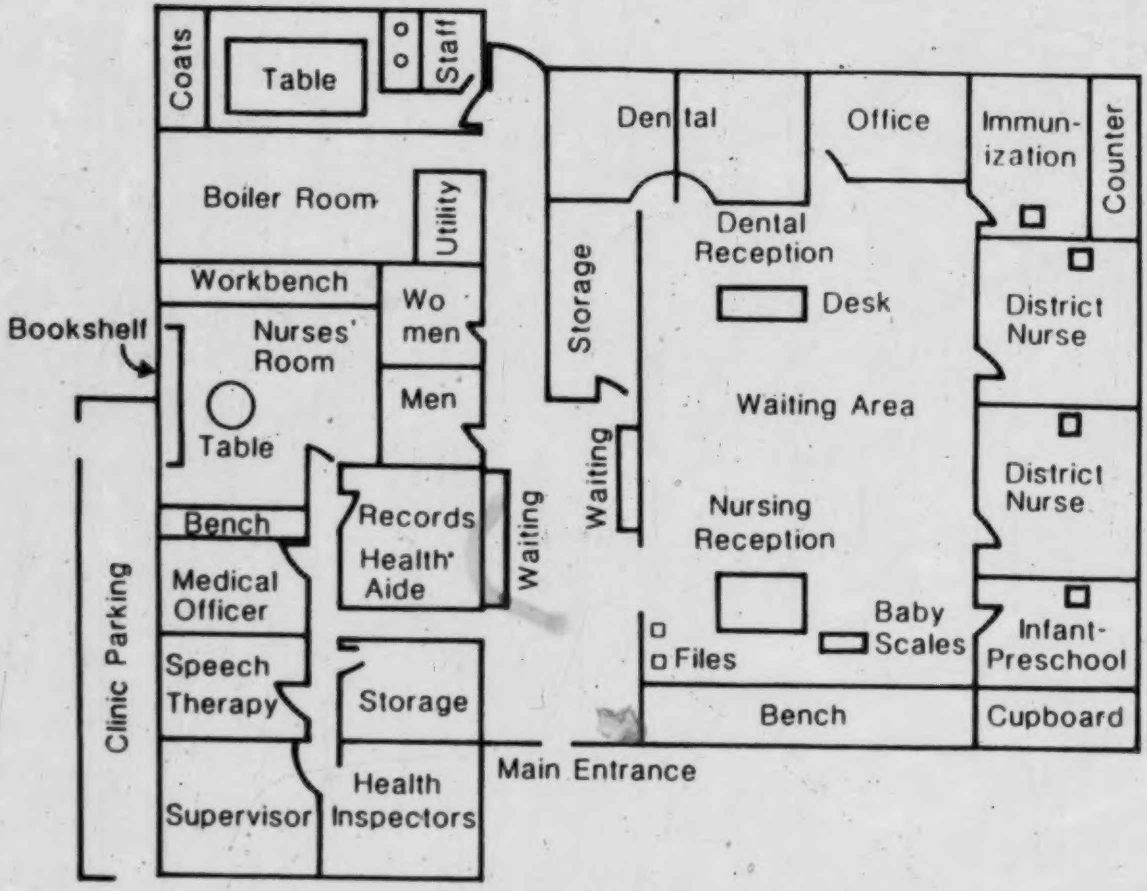
Coats
Table
Staff
Boiler Room
Utility
Workbench
Bookshelf
Nurses' Room
Table
Wo men
Men
Bench
Records
Health Aide
Waiting
Medical Officer
Speech Therapy
Storage
Supervisor
Health Inspectors
Clinic Parking
Main Entrance
Dental
Storage
Waiting
Dental Reception
Desk
Waiting Area
Nursing Reception
Files
Baby Scales
Bench
Office
Immun-ization
Counter
District Nurse
District Nurse
Infant-Preschool
Cupboard

FIGURE 4.1 GROUND FLOOR PLAN OF GREENFIELD CLINIC

Richmond Clinic

Richmond is the satellite clinic in the east end of the area for which Greenfield clinic provides services. The Board of Health rents a room on the upper level of a shopping centre. The clinic is open for clients all day Wednesday. While an apppointment system was in operation it was not unusual for clients to drop in to see the nurse. Richmond clinic is situated in a high density area in which a large percentage of houses are subsidized low rental suites. Many families have only one parent in residence, most frequently a mother, with one or more children and the area had a high turnover in population. This clinic was staffed by one clerk and two nurses who came out from Greenfield clinic on a rotating basis.

The facility consisted of a waiting area, with toys for the children, a storage area, and two interviewing rooms for the nurses. The clerk's desk and the scales were in the waiting area, which, despite having no windows, seemed bright and cheerful. This area was compact in size and encouraged interaction among the clients.

The Greenfield and Richmond clinic settings represent the common working area for all nurses. The districts and the schools that were serviced by the individual nurses will be described in relation to each nurse.

The Climate of the Clinic

The climate of the clinic can be examined along two dimensions, those of the social group and the work group. The social group was formed from all personnel working in the clinic and the atmosphere of that group was congenial. During the five months I was in the clinic there were several parties either in the clinic or elsewhere. The social leader appeared to be Susan, one of the public health inspectors. In October a group went to dinner at a Greek restaurant; in November a party was given for a nurse who was leaving; in December there were two Christmas parties and a bake exchange. One Christmas party was held in the clinic, the other in the home of one of the nurses and the bake exchange was held at the house of one of the dental hygienists. After Christmas there was a curling evening and a Valentine's Day party in the clinic at lunchtime. Virtually all the nurses participated in these events, as did other staff members, the researcher was also invited to attend all these events.

Within the nursing work group there was some dissatisfaction with the conduct of the district meetings and particularly with the way decisions were made. It appeared that the previous year tension had mounted in the clinic. The nurses felt that problems were not openly discussed and that communications had deteriorated. They were determined that such occurences would not happen again in the current year. While none of the nurses felt that the conflict directly affected their nursing, they did feel it utilized energies that might otherwise have been directed toward client care. There was some reluctance on the part of the supervisor to let me attend district meetings which may have been due to the unrest. Nevertheless I did attend meetings once a month and the cause of the nurses' concerns was evident.

Despite these concerns it was apparent that individual nurses were extremely supportive of one another. In the coffee room and the district nurses' room one frequently overheard nurses seeking advice on how to handle a problem with clients or sharing information on families when there were children in different schools. The conflict was generally restricted to administrative relationships and did not appear to affect greatly the peer group relationships in the clinic.

Agency Programmes

The agency provided the nurses with a manual that outlined the philosophy and objectives and also the programmes that were provided for clients. Programmes were outlined for Birth Control Services, Family Counselling, Prenatal Teaching, Child Abuse and Neglect, Infant and Pre-School Services, School Services, Immunization, Communicable Disease Control, Dental Services and Mental Health. The manual did not set out priorities of care within each service, and the perception of agency priorities appeared to be gained through word of mouth rather than through any written policies.

District

The major programme in the district is the infant and preschool programmes of which the post partum home visit is an essential component. The manual states that it is an expectation that all new mothers will be visited and that the purpose of the visit is to check for, "at risk factors not on the birth notice, such as family history, jaundice and the socio-economic situation." At this visit the nurse is also required to assess the degree of follow-up needed by the family.

The bereavement programme is a trial programme and is not outlined. It is located only in four clinics where there is a relatively low well child population and where the proportion of older clients is relatively high.

Visits also occur in relation to communicable disease control, to the assessment of families for dental aid, to school related problems and to the screening of families for child abuse and neglect. In cases of high risk children where there is a lack of medical supervision and where the parents do not bring the child to the clinic, it is recommended that the nurse assess the child in the home.

School

The school health programme outlines five major areas of responsibility for the nurses: (1) screening, follow-up and referral for children in the areas of vision, hearing and speech; (2) immunization and communicable disease control; (3) consultation with the family, school staff, special education teams, physicians and other community agencies; (4) health teaching; and (5) maintenance of required health records and reports. The nurses are provided with a manual in which the programmes are outlined in detail, showing the tasks which should be accomplished for each grade.

Vision, Hearing and Speech

All children are screened for vision, hearing and speech in kindergarten. In Grades I and II all children who have not been screened in kindergarten must be examined. The child's socialization and behaviour in school are also noted. Vision is screened on all Grade II, IV and VII children. A health aide generally does all priority screening early in the year, leaving the nurse to do the routine screening. Hearing is rechecked annually on any child suspected of having a borderline problem.

Health Assessment

The nurse is responsible for making a health assessment on all children who are new to the school and on those referred by teachers, counsellors, parents or who are self-referred. This includes assessing the physical and mental status of the children.

Periodic Health Review

The periodic health review takes place in Grade VII. The nurse is expected to review the child's health status including the history of previous illness. Current medical and dental treatment and any medication the child may be taking are noted. The child's sleeping habits, recreational programs and nutritional status are recorded. The child's vision is also re-checked during this assessment. A list of suggested questions are provided to help the nurse obtain the information. She is also expected to observe for cleanliness and appropriate dress, posture, gait, teeth, mouth breathing, pallor, listlessness and any marked deviation from normal height and weight. In January 1980 scoliosis screening on all girls was added to the health reviews.

Registration and Follow-Up of the Handicapped

The nurse has to arrange for physical examinations for all children prior to special class placement and to ensure that all handicapped children are entered in a central registry. In some schools this is not a major function, but in schools with opportunity classes it assumes more importance.

Health Education

Health education includes individual and small group counselling as well as classroom teaching and acting as a resource for teachers in the area of health education. Some schools will use the nurse as a resource while others will request that she participate in classroom teaching. Maturation classes at the Grade VII level seem to be standard practice.

Consultation and Referral

The nurse is required to visit the homes of children when requested by teachers or when her professional judgement indicates there is a need. She is also expected to engage in teacher-nurse conferences for each class. Most nurses concentrate on kindergarten and Grade I, as they are unable to meet with all teachers, because of time constraints. The nurse is also expected to be available for consultation with school staff, parents and other agencies.

Immunization and Communicable Disease Control

The central focus of the programme is mainly in the clinics but all children attending school receive the initial series of any immunizations they may have missed at school. All the girls in Grade VIII receive protection against rubella and all students and teachers are tested regularly for tuberculosis. In the school the nurses must obtain parental consents, make out lists of children to be immunized, do the immunizations and finally notify parents of the immunization the children have received. In a large elementary school preparing for immunization may take 4 - 5 days of working time, particularly if parents are hard to contact. It appears that the bulk of record keeping is related to the immunization and screening programmes. On immunization day a team of nurses (3 - 4 depending on the size of the school) are involved in the programme. At Greenfield Clinic this meant approximately eight half-days devoted to immunization by each nurse before all the schools were completed.

For the nurses the visual screening and immunization programmes were a priority. They saw this as the agency priority and felt they were evaluated on the percentage of children that were immunized within each school.

Clinic

Clinic is probably the most structured part of the public health nurse's job. The agency provides an outline suggesting what the nurse should discuss with the client at each scheduled visit (Appendix G). Visits are scheduled for infants, at two months, four months and six months of age for primary immunizations and developmental assessment, at a year for the "measles shot" and at eighteen months for an immunization booster shot and Denver Developmental Screening Test (DDST). Parents can bring the child in for a check-up, or to seek advice at anytime. In both Greenfield and Richmond Clinic mothers booked appointments in advance. Adult immunization, often for travel, was also given in the clinic, as were influenza "shots" for senior citizens.

In clinic the nurse is responsible for assessment of parenting skills and assessment of the mother's feeling toward the child and of her coping abilities. It is suggested that the nurse must allow parents to make their own decisions, within normal limits, so that a feeling of competence is fostered. The nurse may offer anticipatory guidance pertinent to the child's health needs and must record progress on the health record. If the nurse thinks there is a deviation from normal she is responsbile for referring the mother to a physician. She may also refer families to family planning, family counselling or mental health services when necessary.

The Denver Developmental Screening Test (DDST) is a simple method for screening for evidence of problems in development and behaviour of infants and pre-school children. The test covers four functions, gross motor, fine motor, language and personal social development. It is considered to be particularly important that this be utilized on all children who are considered developmentally at risk, due to prematurity, stress in the newborn period (e.g. anoxia, convulsions), multiple birth (e.g. twins) and is a regular part of most visits.

Advice on Feeding

The advice on feeding is clearly set out in the policy manual. It is noted that breast feeding is preferred and that the Enfalac and Similac Formulas are the best alternatives. Also the fact that skim milk should never be recommended is firmly stated. Nurses are cautioned on the risks of using cow's milk, on the need to dilute homogenized milk because of its high solute content and on the lack of calories in 2% milk. Solids are not advised until three months, but nurses are cautioned that rapidly growing and active infants may require solids earlier. The final sentence read "these guidelines are flexible", but it was evident in the pilot study that not all nurses saw them this way, particularly when it came to using 2% milk. This was because in inservice sessions, the pediatrician responsible for the guidelines appeared to have presented some strong opinions on the use of 2% milk, and also, to a lesser extent, on the use of homogenized milk. The nurses saw these guidelines as setting out the agency policy (Appendix I).

Major Informants: Characteristics

The four major informants, Carol, Ruth, Kate and Lois, were all nurses, with baccalaureate degrees. Three had graduated from a four year programme which they entered directly from high school; one had completed two years at university following a three year hospital diploma program and two years of nursing experience. The age range of the subjects was twenty-five to thirty-five. Three of the nurses were married and one was widowed. One nurse had a son of pre-school age and another a daughter who was in Grade I at the time the study commenced. Work experience in nursing ranged from four to thirteen years. In community health nursing the range was two to five years.

At the start of the study all four nurses were working at Greenfield Clinic. Three of the four nurses were district nurses at the onset of the study, the fourth nurse held the position of infant and pre-school nurse (Figure 3.2). In February the fourth nurse became a district nurse but remained at Greenfield Clinic. In December one nurse was promoted and moved to Redfield Clinic, situated in a middle-class area of the city.

At the onset of the study one subject was known to the reseacher. This nurse had been a student in a course taught by the researcher two years previously. The other subjects were unknown to the researcher prior to the commencement of the study. Their perspectives will be explored in the following chapters.

The Perspectives of Nursing Held by the Nurses Who Were Colleagues of the Major Informants

All but one of the nurses at Greenfield Clinic were interviewed, the one nurse did not respond to the request and to avoid any question of coercion no pressure was applied. Their perspectives on nursing will be presented in summary form.

Five of the seven informants said the purpose of public health nursing was to prevent illness, the other two saw it as a promotion of client's health. All the nurses saw school nursing as utilizing the major portion of their working week. Their priorities within the work situation differed and there is evidence to suggest that priorities were related to personal preferences. For example, a nurse who liked older people was more likely to see visiting them as a priority than one who preferred new babies. The socio-economic level of the clients also influenced the nurses' priorities as this, in turn, influenced perceived client needs. Functions of the nurse that were identified included case finding, educating clients, referral of clients and helping client's use available services effectively.

There were two major reasons the informants had become public health nurses. One group selected the field for professional reasons, such as a commitment to prevention of illness; a second group for personal reasons, such as regular hours. All the nurses who fell into the second group had previously worked in hospitals. The nurses saw themselves as independent and able to make their own decisions on day to day priorities within the field.

Satisfaction in the job was generally related to positive responses from clients, working with well people, the variety of activities within the work situation, and the fact that the decisions made about clients were the nurse's own decisions. Frustrations were related to the difficulties encountered when the nurse and client held different values; the fact there was often insufficient time to do a "good" job with the cliens, dealing with other agencies (particularly social work); and the amount of paper work involved in maintaining records, particularly in the schools. Five out of the seven nurses felt daily contact with colleagues to be important as they saw the job itself as a relatively isolated one.

Continuing Education

Because continuing education took a relatively large percentage of the nurses' time, the common programmes engaged in by the nurses in Greenfield Clinic, will be outlined in this section. There were two types of continuing education, "inservice" and "outservice". Inservice was used to refer to programmes offered by the agency itself and outservice to those programmes offered by outside agencies that were considered by administration to be of legitimate value to the nurse in her work. Nurses were allowed a certain number of days for outservice each year if there were courses, workshops or professional meetings they wanted to attend. There were two major inservice projects provided on a city wide basis that were being offered while I was in the clinic, these were a four week series on Human Genetics and the Values, Attitudes and Practice (V.A.P.) training sessions.

Human Genetics Workshop

The human genetics course was a series of four sessions, offered each Thursday morning from 8:30 a.m. to 11:00 a.m. for all nurses working for the agency. Specialists in the field were brought in to speak to the nurses and a manual was distributed to each clinic. It was hoped that in the future the nurses might become more involved in genetic counselling. This was an introduction to the topic, the purpose of which was to alert nurses to clients who might benefit and who should therefore be referred to an already established counselling service. All the nurses at Greenfield Clinic, with the exception of one nurse who retired at the end of November, attended these sessions.

Values, Attitudes and Practice Training Sessions

This was a two-part course given by a clinical psychologist employed by the City. Dr. Burton, the psychologist, identified three goals for the programme:

1. To provide a framework within which the nurse can examine the effect of her attitudes and values on her own practice.
2. To provide a framework within which the nurse can look at public health nursing in light of the underlying philosophy of public health. The nurse must understand the significance of the client as human actor and as human target. Public health has as its essence a health orientation as opposed to a disease orientation, and a public as opposed to a private sector orientation to care. Nurses must also be able to understand the difference between public health nursing and acute care. Basically, Dr. Burton hoped that at the end of the programme the nurse will understand more about the society in which she lives, that each client has his/her own special set of beliefs and values and how these values are imposed on the conditions and trends in the culture in which they live.
3. To provide some experiential learning in relation to some skills administration believes the nurse should have.

The programme was started following a survey of the nurses. The purpose of the survey was to determine what factors get in the way of allowing the nurse to function in the job to her own satisfaction. The survey looked at inter personal, inter agency and intra agency factors and came up with eighteen categories. These were circulated and the nurses were asked to identify their priorities. The needs identified by the nurses fell into five areas and learning packages were developed and offered to the nurses. During the first inservice sessions further gaps in skills were identified and finally eleven education packages were developed. These were offered in two series of five and one-half day workshops.

The first series consisted of an introduction, followed by four further sessions. The first of these dealt with self-awareness and its significance for practice. The second examined logical inference, objective observation and the difference between them. The third session focussed on information exchange, the provision, retrieval and validation of information. The last session looked at the development and use of support systems. As teaching is seen as a major strategy of the public health nurse it was hoped that the nurses would transfer process skills to the client so that they in turn could improve information exchange or develop support systems.

The second series looked more at substantive areas such as teaching, problem solving, consultation, programme planning and change agency. The focus was more action and skill orientated than the first series where the emphasis was on conceptualization. Dr. Burton believes that many public health nurses talk about programmes because they are unable to conceptualize about public health nursing. She feels that in this training series the nurse must learn to conceptualize so that she may act more effectively with clients.

One shortcoming in the programme was a lack of follow-up in the field. Dr. Burton felt it to be unfortunate as many man-hours had been put into the training programme. She has had some unofficial feedback when working with nurses on case conferences or programme planning, but she would have preferred a more systematic approach. Also, when the first nurses took the training sessions, there was a lack of support in the clinic situation, but she believes this is improving as more nurses are becoming prepared. The supervisors are now taking the program and all assistant supervisors have received values, attitudes and practice training. Dr. Burton admitted she had her biases:

> If you don't know how to conceptualize you sure as hell aren't going to know how to modify or to know where to deviate when you need to deviate or reinforce where you need to reinforce. You've got to be able to conceptualize - so that's where I'm going to put my weight...if time is short and I have to skimp on anything I'll skimp on application.

Although the plan is to spend one day on application in the second series, if the nurses' conceptual grasp following the first series is not sound, then more time will be spent on theory. Dr. Burton felt that if the nurses have grasped the concepts they will practice by themselves in the field. At the time this study commenced Carol and Kate had taken both series of V.A.P., Lois had taken both series but had to make up some packages in the second series and Ruth had only completed the first series and was scheduled to take the second series in Feburary-March, 1980. Carol and Kate spoke of the series as being helpful. Lois felt she could apply it to herself but could not yet see how she should apply the ideas to her work and Ruth did not refer to V.A.P. spontaneously, but said she found it interesting when she was asked. Carol and Kate both felt that they tried to use some of the concepts in their daily work.

The Group Dynamics Workshop

This workshop was restricted to the nurses working within the clinic and resulted from a need identified by the nurses to have outside help in solving problems they perceived to exist in the group process. It was run by a psychologist specialized in group dynamics. Kate originally suggested utilizing his services. With help from Hazel, (a nurse whose district was next door to Kate's) Ruth and Carol were responsible for organizing the sessions. They were held five mornings a week for two weeks in January with the nurses working in clinic, completing home visits and dealing with urgent problems in their schools each afternoon. Thus the work of the clinic was continued albeit on a somewhat restricted basis. During this period my participation in the clinic was limited as the nurses did not feel my presence at the sessions was appropriate.

Summary

This chapter has described the major characteristics of the setting in which the four major informants worked. A summary of the beliefs about nursing held by the colleagues with whom they worked was also presented. The next four chapters take the form of four cases studies presenting the perpectives of Carol, Ruth, Kate and Lois. A perspective can be said to have three dimensions, those are the individual's beliefs, actions and judgements and these will be presented within the context, in which nursing occurs.

CHAPTER 5

CAROL

Introduction

Carol is married, in her twenties, a graduate of a basic baccalaureate programme and she has nursed for five years. Her goal in entering nursing was to become a public health nurse. "I think I can honestly say I made this decision before I ever went into university." Her experience while at university reinforced her original decision. "Having worked in the hospital I found it very difficult...to work where my thoughts and decisions weren't particularly important." She saw herself as not having control over her nursing care: "I didn't seem part of the decision making process about patients...and I just didn't want that...that's where I just made the choice." She had to work one year in a hospital after graduation. "I needed a job as soon as I graduated, but the Public Health unit wouldn't hire the girls until they actually had their little card of certification in their hand...." She spent the year nursing in a unit for disturbed children, "it certainly wasn't wasted...so much of my work is with children, mother's asking my opinion, and I have no children of my own so it's been a really nice experience to draw on." Carol indicates here that she utilizes practical experience as one of her information sources when working with clients.

Personal Characteristics

Carol sees herself as "a fairly organized person" who "gets along with most people fairly well." She is "flexible enough that I can accommodate other people's differences in beliefs so that if they don't exactly match mine that's O.K." She believes she has "a sense of humour" which she uses "to ease tension".. "I'm very confident of myself...I know what to do, what my ideas are. I'm direct and I do sometimes believe I am quite aggressive." She views indirectness as "undesirable" but when she feels "unsure of myself I may use an indirect approach." She is also concerned that being aggressive "isn't always good." In discussing what she sees herself as bringing to nursing Carol said, "I have a lot of enthusiasm, a lot of drive and I think I bring to that what I know from my experience."

As a nurse Carol thinks that respect for others is important. "I certainly believe that humans and human life are very precious and that every person is precious...that certainly directs how you see any individual no matter what their circumstances are like." Despite this belief Carol feels that one has to be careful not to be judgemental of others. "It's easy to criticize or say she's a terrible this or that" but, "if I recognize the worth of the individual it does direct how I work with people."

The fact that she is decisive in her own life presents a conflict for Carol: "I think I'm very much, 'well this is the decision...so let's go do her.'" She recognizes this is not everybody's way of acting, "but when it doesn't move fast enough for me I get frustrated." She herself feels better after she has made a decision, so when clients do not act to get out of a situation she views as needing improvement she thinks, "so, why don't they do it."

> I feel almost urgent sometimes about the number of people I see that aren't...that aren't in a disaster situation, like life isn't just rock bottom...life just isn't good...it's not really happy, they just sort of live. (29/9/79)

She reflects "that maybe this is O.K.", but is unable to accept this thought:

> I get feeling urgent there is more for these people, for anybody and you can be happier, or you could be, and when I see them in this situation they're not sick but they're not really optimally healthy and I get frustrated. (29/9/79)

For Carol growth and self-actualization of the individual are an essential part of being healthy. Despite her awareness of the need to avoid judging others in relation to her own standards she has concern when individuals do not recognize the need for change. She believes that as a nurse she should be flexible, but also, "there's a point where you don't compromise what you are no matter how flexible you think you should be". When that point arrives "I just don't bend".

Public Health Nursing

Carol says, "I'm really turned on by Public Health Nursing...I think it's the nursing of the future...it's where our time and effort should be put." Her personal goal is "to promote the health" of her clients:

> I hope to look at a fairly healthy group of people and help them maintain their health...to me to start at zero and be going into the plus is a really good feeling - to have sickness and to make people well...that has a certain amount of joy...but to me, if people don't have to get sick in the first place that's even better. (29/9/79)

"I'm very turned on to health", and for her it is satisfying to see that clients can in fact "help themselves." She is not sure if her colleagues agree with her goals for promoting health.

> The bad thing I feel about public health is that I don't know if there is a shared community amongst public health nurses. I've mentioned promotion...that I believe we're at zero or better and should be going toward the positive. Now maybe this is being presumptuous that I know what it's all about (laughs) I don't believe that's true, but I do believe that is what public health is and that if we all understood what we were trying to do we should have more impact. (29/9/79; reiterated 10/3/80).

Carol also has concerns that clients may not see the value of this perspective:

> Maybe they don't believe that not to have huge outbreaks of polio is a good thing...because it can't be hung onto. It's not concrete...it's difficult. (29/9/79)

Despite the conflict she feels between her values and those of her colleagues and her client Carol is clear about her goal for her nursing actions.

> I truly believe that our goal should be that 'I don't want to see you again because you now, in fact have resources to handle things on your own.'

To help people to make their own decisions and to live fairly independently "is a nice feeling...that's what I like...and that's what I work toward too." When describing a situation in which she felt satisfied with her nursing care Carol selected a client who had recently been widowed:

> I really felt that I did a lot of good....Now she's at the point where she's seeking out her own support system, with, for example, a widow's group.

In order to reach her goal in an interaction with the client Carol believes she must "help this client make one step toward independent decision making". If she achieves this "I've done my job". Her goal is centered around the fact that a decision is made, "not what she happens to decide, or that this was good or that was bad...but that she's made a decision." Carol says her approach to a client is centered on the notion "mostly I'm just interested in helping you help yourself." She sees that as her priority "no matter what the situation." Yet she acknowledges that she is not always able to achieve this, "I can honestly say that there are times when I'm not going to do this, because I'm tired or I didn't have the time."

This worries her because "it may solve the problem in short term but I don't believe that it does for the person in the long run." Carol believes clients "have a lot of knowledge" and "probably have all the answers"; what they need help with "is to help sort out facts... perhaps help with the decision making process." Carol identifies her role as one of providing guidance and support for the client "I'm striving to nurture an attitude of learning and enquiry....If I can say 'Ask questions, question me, question your doctor, question your teacher', if I can even spark that in a client I've accomplished something." She also believes that the client may need information, but "I'm providing knowledge because I'm a nurse and know a few things." However, she believes that in providing information she would expect the client to react by saying "What about this? Does that hold true? I want them to talk to me."

When Carol speaks of group teaching, however, the focus appears to shift from clients to teacher. She views herself as "a good teacher" who "gives information well." She believes she has "a good presentation manner" and she observes "they learn when I teach them." In group situations she seems to focus on the teacher as informant, but in one-to-one situations the focus appears to be on "facilitating learning in helping people make their own decisions or helping them ask themselves the right questions." This is, to her, "a broader sense of learning and teaching" which she sees as "very important to our work too."

Summary

In symbolic interaction theory, self-indication allows an individual to interpret reality and to act on that basis. Self-indication, in turn, depends on the individual's definition of the situation which may be called a perspective.

Carol's goals are the backbone of her definition of the situation. As the descriptions are presented, the perspective which is identified is one of assisting the client to achieve his maximal potential by encouraging him to seek his own answers and make his own decisions. Carol believes that if this goal is achieved clients will have improved the quality of their life. The goal is achieved by transaction between the nurse and the client. The nurse, through her professional knowledge base, provides information but also respects the knowledge base of the client. This means that both strengths and weaknesses of the client must be identified for nursing care to take place. In Carol's case the goal facilitates the intended outcome of her perspective and is also the intended outcome of her actions.

In order to understand Carol's perspective on the goals of public health nursing and the prescriptions she sees as important for reaching those goals it is necessary to examine the context within which her nursing takes place.

Common Events in a Working Week

In public health there is really no such thing as a "typical" day. Nurses are able to describe common events that occur over the course of a working week. Events include places and activities the nurse perceives as being frequent in her working day.

Carol, in common with most nurses at Greenfield Clinic, comes in first thing in the morning to talk with colleagues over a cup of coffee. She sees this as important. "You're not on a ward and you're not working shoulder to shoulder so you lose contact with each other and you must have the support of your clinic." This is also the time for trying to make telephone contact with clients, either to "follow-up on school problems or to make appointments for home visits." Most mornings "if we don't have meetings" Carol goes to one of her two schools. "Schools are a really important part of my job" however when she arrives she sees herself spending much of her morning doing clerical work. She finds this frustrating. She must find out "who's going in, who's going out", then order records. "It means the secretary in your school must really be your buddy or you don't get a lot of this done." Within the school Carol also attempts to see "students that are referred to you" and tries "to spend a certain amount of time with my teachers going from class to class." She relies on teachers and on the Principal and Vice-Principal to "pinpoint some problems."

They may suggest a home visit. "They will say...this kid, there's something wrong, probably you need to look at what's going on in the home." School nursing usually occupies most mornings when there are no meetings.

In the afternoon it varies "from clinic, which is fairly straight forward, to my home visits." When Carol is doing home visits "I usually put a priority on baby visits unless there's something else pressing...a diphtheria case or T.B." At the time of the initial interview Carol had a family on her caseload who were being treated for diphtheria. Because nose and throat swabs had to be taken at prescribed times, all other visits have to be organized around this family. Communicable disease visits were common but visits to a family with diphtheria were in fact a rarity. In an afternoon Carol says she can do "three or four visits depending on the time they take." At the end of a day she comes back to the clinic to "sort material, get rid of what can be put away" and "organize my day for the next day." "Sometimes I read (laughs) not very often". "In the summer, when there are no schools to visit, we have more time to catch up on our literature... it's really good how we have all kinds of staff to keep us up to date." I asked Carol about meetings and she said, "All days are meetings." Carol is active in the staff nurse association and sits on the city wide prenatal resource committee for the clinic. She is also active on committees within the clinic.

> We had a bereavement programme and we had some concerns about the goals and directives of the programme. We felt we needed to talk about it in our own clinic...so three or four of us sat on this committee.

Carol sees this part of her work as important:

> I like to be involved with those things because that's important you know, to my growth...my own mental health in my work, so that's important, so I like to spend some energy and time on that.

As far as the Staff Nurses Association is concerned:

> It seems to take up a lot of time...sometimes I get frustrated but that's up to me, how much of my time I want to volunteer.

Teaching pre-natal classes and parenting classes in the evening is also an expectation in the job. "We take it in turns. Currently I'm supervising the university students who are teaching the prenatal series. They're doing a great job."

The settings described by Carol in which she cares for the client include the school, the home and the clinic. Her work also includes an expectation that she will do parent teaching and serve on agency committees. Having described how Carol defines her situation I will now describe her actions and the criteria of judgement she used as she provided nursing care for clients. Her actions will be described in relation to the settings in which they occurred, the district, the school and the clinic.

Carol's District

Carol described her district "as mostly lower class, with a relatively high [population] turnover. I have quite a few families where English is the second language, some Italians and Portugese and native Indians". As she drove me around she pointed out new duplexes standing amongst thirty year old houses. The new duplexes "mostly belong to Italian families, often you find relatives living in the two halves."

There were many old wood frame, two storey houses, which were in disrepair. "In the district they're known as 'Indy' houses, and frequently they are inhabited by natives, but they're all rented and the landlords never do anything to them."

Carol's district at Greenfield ran 25 blocks north-south and 22 blocks east-west so was reasonably compact. The clinic was within her district, so she had easy access to it at lunchtime or at the beginning or end of the working day, thus she maintains frequent contacts with colleagues. Within her distrct were two schools, Shipton and St. Frances. In January, half way through the study, Carol moved to Redfield Clinic, and encountered a group of clients who she perceived as being "different from Greenfield". They owned their own homes, had at least Grade XII education and often had attended university. "The houses are older, but.you can see the new paint, the yards are neat, you'll see the difference when we go out to visit." My own observation of the area confirmed Carol's description; the two areas differed greatly in the impression they created.

Home Visits

I asked Carol how she evaluated the level of functioning of a family when she made a home visit.

> I certainly look at the physical surroundings. Now "neat and tidy" is meaningless, but "clean" does mean something. Now I don't mean "scrubbed" or "spotless", I just mean clean. And to a certain extent some order, not rigid order, because with children order is thrown out the window. But if one finds that there is some order in the household that means to me that you are a person who can get up and be a little planned about how their life is run; and although children certainly disrupt, that's okay.

Assessment of the Individual

As far as the individuals are concerned, Carol looks at "their general appearance" and "how healthy they look". She looks for "physical signs of whether they take care of themselves," for example, "if they are washing or not." Nutritional status too can be assessed "from the way they look.". The client's ability to articulate how they are feeling is also important. If the client is able to say how he/she feels "I know they have probably thought about their problems and have a little bit of a grip on what's going on and what's right." If clients are unable to provide "any sense of their problem" then Carol feels "they are in a lot of trouble. They can't even tell me. For her the client's ability to speak of a problem, however superficially, suggests that they are "one step above 'zero' functioning."

Nursing Intervention

Carol states that the first stage of care with any client is the identification of the problem and "that can sometimes take a long time, because they think they know the problem, but in discussion, it isn't a problem." So the nurse's role becomes one of "gathering and extracting or sharing information." She sees the next step as one of reflection with the client. "Here's all the information, now can you tell me the way it is and the way you want it to be?" In between the way it is and the way you want it "is your problem." Once you know the problem you can "proceed to the alternatives."

Sometimes when the client has the alternatives that is as far as nursing action has to go. However, some clients may come back and say "look, I don't think I can choose, I need more information" or it may be "I need more time". Carol also says clients may ask, "What would you do?" Depending on the client, I may say "I would do this, but always [I would tell them] 'I am me, that is why I would make that decision.'"

Respect for Others

One of the earliest visits I made with Carol was to the Pichet family. (1/10/79) They lived in a two storey home. The yard was littered with toys, the house unpainted and a window on the porch was broken. Carol knocked on the door (there was no bell) and when there was no reply she opened it and called out and we were told to come in. Colin, an eleven year old, had had a positive throat swab for diphtheria and the family were in quarantine. This visit was to obtain throat swabs. Two series had to be taken on all members of the family, twenty-four hours apart, following a course of antibiotic therapy.

The house inside was sparsely furnished, the floor bare but clean and baptismal certificates and a crucifix decorated the walls. The family came from a reserve in Saskatchewan and had lived in Edmonton over a year. There was no father in the home but Mrs. Pichet's brothers were frequent visitors. The children's first questions to the nurse were all related to school. It seemed they were anxious to get back.

Carol had been previously to check that the children were taking their medication and were remaining isolated from their friends. She had explained that she would be taking swabs but checked again with the children before she began.

> Now you understand what I'm going to do. I have to take swabs from all of you today and then again tomorrow.

> Mrs. Pichet: I sure hope they're all right because these kids are beginning to drive me mad.

Carol responded to the feeling Mrs. Pichet expressed and reinforced her contribution to the children's treatment.

> I know you were most conscientious about giving them their medication, so I'm sure the likelihood is that they will be.

There was no telephone in the home and so she added: "I'll call around Thursday and let you know or else I'll get one of the other nurses to come if I'm tied up."

The two younger boys, Colin and Aaron, clamoured to be first, but Carol said she would prefer to do the two youngest children, Noella and Michelle first. She rewarded the children with praise for their cooperation. "Excellent, you really are a good patient."

I asked Carol about her use of the words "patient" and "client" and she replied: "I think I use them interchangeably." She then qualified her statement and said: "'patient' to me traditionally means someone who is sick, you are called patient in the hospital; whereas a 'client' can be a well person. But, I don't think I distinguish, I may just say one or the other."

Carol had also acted as messenger for the teachers at St. Frances school. She told the girls that the teachers were asking after them and had brought Winston some homework.

> Now Winston, I talked to Mr. Stevens (home room teacher) about your work and he said his only real concern was your math. He sent you these math and social study worksheets. You are to do the math test without reference to the books and notes from class.

Winston said "That's no problem - I don't have them home." When we went to St. Frances the next day the teachers asked Carol about the family. They spoke positively about all the children except Colin. When we returned on Tuesday afternoon to repeat the swabs it was obvious that he was the child who Mrs. Pichet had most trouble controlling. She rarely raised her voice to the children and was able to find diversions to keep them amused, but after Colin had clattered up and down the stairs several times she yelled at him, "Get up to your room and stay there I've had as much as I can take of your noise." In contrast, Michelle said excitedly, "We've had a bath." Mrs. Pichet explained, "The girls love playing in water, they were getting on my nerves, so I put them in the tub with their toys to get them from underfoot while I did the wash."

Carol asked Winston how his homework was coming and his mother said he worked at it all morning. Winston replied, "I did some...but I don't understand what I'm meant to do." Carol volunteered to look at his books with him after she had taken the swabs. It was obvious he found the problems difficult and she said: "It's hard for you to do this without looking at your notes. If you can't go back to school on Friday, I'll ask someone to get your books from your locker."

Mrs. Pichet remarked that "all the children love school and they can't wait to get back."

In evaluating this family Carol commented on Mrs. Pichet's compliance with the medication orders "she woke them up at night so they had the antibiotics every six hours." She remarked how clean and tidy the house appeared to be each time she called. Also "the children are always clean and tidy in school." Carol also noted that the children were disciplined. "She didn't need to yell at them to get them to behave. It was obvious that she had expectations for the children." Another comment was directed toward Mrs. Pichet's problem solving ability. "I was impressed, when the little girls got fractious she put them both in the bath and let them play." (1/10/79)

Carol had earlier stated that she did look at the cleanliness of a house in evaluating the competence of the family. While she said neatness was meaningless she did use the term in evaluating the Pichet family. She felt that the obvious ability of the mother to control the children showed an ordered household. She also said Mrs. Pichet was able to find solutions to her problems and she saw her as functioning in a positive manner. In this instance Carol's concern for the family extended beyond the task of getting throat swabs from the children. She showed concern for the mother's welfare when she was confined to the house with four children and for Winston's progress in school. She respected this family as existing in its own right and as striving to grow. This is one of the conditions that Mayeroff (1971) states is essential to a caring relationship.

The Decision Making Process

Later in the week (5/10/79) we went to visit Charles, a 51 year old Métis, who was receiving drugs for treatment of tuberculosis. Some months previously his common-law wife of twelve years, Vivienne, had left him. He had had a back injury two years previously and had been receiving social assistance for the past eighteen months. "I always worked hard, logging, the lumber camps. This is no life, you exist on social welfare". He had started to drink following his accident and he recognized that he was at this point an alcoholic. "I know I have a problem, I drink and can't stop - but when I have too much I lie down and sleep."

Understanding the Client

Charles lived on the ground floor of an old house. There was a kitchen, living room and bedroom. The bedroom had a mattress on the floor and clothes lay in piles in and around suitcases. There was a hole in the living room ceiling and the paint was peeling off the walls. "It's a mess, but I can't paint it with my back. The landlord gave me a piece to patch the roof but I can't reach over my head because of the pain". When we arrived Carol had knocked at the door, opened it and called out "It's Carol Venning, the nurse, Charles" and we went in. Charles wore grey slacks and a white undershirt. He looked clean and his beard was well kept. He said, "Come in, come in, we're celebrating. I got married yesterday."

Carol replied: Vivienne's back. I'm so glad for you Charles. I know how unhappy you were when she left.

Charles: I don't know what I would have done without you and Dr. Peters (the pyschiatrist to whom Carol had referred Charles). I suppose you've come to give me heck about those pills? (Good humouredly). Well, I've been celebrating, so I haven't taken them. I know they don't mix with drink.

Carol: That's right Charles you can't take them when you drink - but I didn't really come about the pills but because you seemed so depressed the last time I was in. I was worried about you.

Vivienne came in. She was glassy eyed and her gait was unsteady. Her blind mother was sitting in one corner and her nephew, a young Indian, dressed in clean, well pressed jeans and shirt, was sitting in a chair by the door. Vivienne sat on the opposite side of Charles to Carol.

Charles: I'm better now. I was married yesterday - we made it legal after fourteen years, didn't we Viv?

Vivienne: Yes, we're married (to Researcher). Aren't you going to congratulate me?

Researcher: It must have been a big day for you.

Carol: Congratulations Vivienne.

Mother: Who's there?

Charles: The T.B. nurse Mother.

Mother: Just the regular T.B. nurse.

A few minutes later Charles went to find his car keys to give to his nephew. Carol moved over, put her hand on the mother's arm and said:

> I'm the nurse Carol Venning. I've been visiting Charles for some time now because of his T.B. I'm sure you must be happy about the wedding.

Mother: I am, I am.

Charles returned. In the next few minutes he and Vivienne became embroiled in an argument as to whether or not she had recently taken "drugs". She swore she had not had any drugs.

Vivienne: Holy Mother of God - so strike me dead if I am lying. I had whisky.

Charles did not believe her and kept persisting and the situation became tense.

Carol: Charles I can understand your worry about Vivienne and pills but she is only getting angry when you ask her.

Charles: Damn right she is. She'll deny it and deny it but I know she's had pills. Look at her - she's high. Whisky - she don't smell of whisky.

Vivienne: I gave up drugs. He can give up whisky.

Charles: She was on heroin. You should see her arms - black they are - but she gave that up. It's those prescriptions, librium.

Vivienne: Give up drinking. I need pills for my nerves. The doctor says so. You're an alcoholic.

Charles: I know I'm an alcoholic. I've been in the Royal Alex. I'm going to start their course --- I talked to the doctor.

Carol: Charles you've been saying for a while you're going to quit - but you've kept on. Vivienne has a point. If you expect her to stop taking pills you need to stop drinking. That's only fair.

Charles: I know I was bad when she went - but I was so low.

Carol: I know you were Charles, but now you have Vivienne to care for. You can't drink and take pills and you need to get your T.B. controlled.

Charles: I plan to. I've been to the Alex. I will talk to Dr. Peters again. He really helped me. Vivienne you have been taking pills. I know you have.

Vivienne: What's she doing - she not talking (referring to Researcher). Is she a spy? I've been clean eleven years. No dope, no nothing.

Carol: It's all right Vivienne, she's observing my nursing. She's not here to ask questions or to tell anyone about you.

Researcher: I'm sorry Vivienne. Is my sitting here bothering you?

Charles: She's high - she's had pills.

Vivienne: I have not.

Carol intervened at this point by changing the focus of the conversation.

Carol: I'm glad Vivienne is back Charles. I know how you missed her (pause). Please get in touch with the T.B. clinic and get a new order for your medication.

She acknowledged Charles' feelings before refocusing attention on the purpose of her visit.

Carol: You've been off the pills too long and you really need to be reassessed. I will come back and see how you are doing. I do care about how you do.

Charles: I know you do nurse.

Charles got up and walked with us to the door, speaking of his concern for Vivienne.

Carol avoided taking sides with either Vivienne or Charles, but she did try to reflect with him on the reality of the situation. She was outwardly unperturbed by the argument between Vivienne and Charles. She was aware of the other people in the room and made an effort to include Vivienne's mother in the conversation when she had a chance. In summarizing the visit Carol demonstrated her understanding of Charles and his problems:

> Charles has an awareness of his problems and he has made contact with the clinic. Now Vivienne is back this may result in action but he has had good intentions for some time. Charles really is concerned for Vivienne, hence his harping about her taking pills. I think she certainly had taken drugs - probably librium, but to her drugs seem to be the hard stuff, not medication ordered by the doctor.

Her comment to Charles, "I do care about you" was in line with her belief that people must know someone cares about them before they can carry on independently. "Until you can be propped up by someone, you can't have a feel for your own power to do things." Her action in referring Charles to Dr. Peters also provided him with a prop. She was pleased however to note his independent act in contacting the Alcohol Treatment Clinic.

Assessment of Client Motivation

Later the same day I went back to the Health Unit with Carol. Vera spoke with her about Dolores, another client who came for tuberculosis follow-up. She had to collect her medication from the clinic.

Vera:	Did Dolores come for her medication?
Carol:	Yes...and she's off to the Whitefish Reserve up North, and to tell you the truth I hope she stays there.

I asked her about Dolores to get the background to this comment.

Carol: She has active T.B. and because she is a known defaulter she has to come to the clinic to get her medication, but has not been since July. The physician at the Aberhart was about to initiate court action to get her forcibly hospitalized when she turned up for her drugs. (5/10/79)

In contrast to Dolores, Charles' tuberculosis was inactive and so he was not a danger to other people if he failed to take his drugs. It was difficult to relate Carol's persistence in his case to her obvious relief that Dolores had left the city. I asked her about this during a subsequent interview:

> Charles was able to tell me what his problems were. I think we discussed together. He knows he should take his T.B. drugs. He is also smart enough to know that when he drinks he better not take his T.B. drugs. The two don't mix. So he will tell me that; then I have to think "Why is he drinking?" His whole life is such a turmoil. His girlfriend left him and that was just really bad for him. So, my feeling with Charles is that if he can get some kind of stability in his personal life, and a better feeling about his self-esteem, that in fact, he would be no problem at all. That's why I persevered with him.
>
> Dolores - not to suggest her self-esteem was not low - but I don't get the same feeling with her, that if she got her life fixed up, that she would, in fact, be any better with her medication. She

> was in a worse situation. She was so negligent with her drugs that they had to put her on strict "You come to the clinic" and that's a few steps behind where Charles is at, as far as being negligent. He understands the effects of drink and drugs - and chooses drink - but his decision is a considered one. (22/2/80)

Evaluation of Client Potential

In November I made another visit to Charles with Carol. We again knocked, called out and walked into the house. A cousin, who was a decorator had visited and the ceiling was repaired and the room was painted. Vivienne was bright and alert and chatted with us. She showed no sign of drugs or alcohol in her behaviour. However, Charles still had not taken his pills and was still drinking. His car battery had given out and he could not afford a new one so he had not been to the Alcoholic Clinic. "I can't take the bus I know it sounds stupid, but I'm scared of getting lost." He spoke of wanting to work "I'd like to go back logging. It was good money, but my back won't take it. I've talked to this cab dispatcher and maybe I could drive, because sitting is O.K." However, he again expressed fear of getting lost. "I'd be all right in the main part of the city - but the area around Castle Downs is a maze - I wonder if I'd ever learn it." (7/11/79)

Carol in reflecting on Charles and Dolores continued:

> When his wife came back, they got married. That was obviously so important to him and made him feel so good. When he was up, he was able to say, "My back hurts but I am thinking if I can get my cab license, then I can provide myself with money that I need to just live." He was able to make plans. Like...he was able to plan ahead, which a lot of them...like Dolores for example, she never showed me any signs of having planned for her future. And, a lot of things like, "Look Charles, you never get to the Royal Alex. What's the problem? Why don't you go there? You have told me you would." He is able to articulate instead of saying "Well, I just don't want to go "[it's]" my car is broken right now, and you know, I hate like anything to use the bus". He just makes sense to me. He is not just giving up, or it's not that he hasn't thought about

> it. He can tell me legitimate reasons. I mean some people may think that using the bus is not a good reason, but I could hook into that. So, he was able to plan, and also able to reason why this is what he does. It may be significant also, that he can articulate [what he thinks]. Now, in fact, Dolores may have the very same kind of fears, but either her intelligence, or non-trusting of me, or whatever, is to a point where she can't articulate. But his being able to say those things showed potential to me. And that's why I was putting effort into Charles. (22/2/80)
>
> Researcher: When we last went to the house the room had been painted too.
>
> Carol: Yes, that is significant when I can compare it with other people with very similar situations who do nothing. When I only have so much time, my effort has to be focused on what I think would get the best results, [I think] will we get somewhere with this?
>
> Researcher: Um, huh. So, you are saying here that you only get so much time. Therefore, if you really think you can't achieve anything, you are going to select someone who shows some potential...
>
> Carol: Yeah, yes.
>
> Researcher: Because you can't work with everybody?
>
> Carol: No. And if someone I perceive is going to take a long-term follow-up intensive kind of work, I will refer them to the proper agency, that in fact, will do that. And in fact, Dolores may need to be seen by Provincial Mental Health, and have a worker out there weekly. Um...even then she may not change. (22/2/80)

Carol based her evaluation of the visit on her assessment of the individual's potential to change his behaviour. She sees Charles as making decisions and, as she said earlier, "I don't mind what decision the client makes as long as they show some evidence that they can make the decisions which fit for their life." (29/9/79) She feels Dolores may need help from other professionals if any changes in her acceptance of responsibility for her health care is to be achieved. In caring we must experience the other as having potentialities and the need to grow. In addition, one must experience the other as needing "me" in order to grow before one can care for another. The relationship is not one in which one individual dominates the other; but is based on a kind of trust (Mayeroff, 1971). Carol experienced this type of relationship with Charles but not with Dolores.

Rejection of Care

Many clients in Carol's district did not perceive themselves as needing assistance from the nurse and this was particularly evident among the native population in the area. We were asked by the Principal of St. Frances school to check on Jacqueline, a girl attending Grade I who was in a special reading class, and her sister, Roberta, who was in Grade II. Jacqueline was frequently absent and her teacher noted she had had frequent colds and so it appeared it could be a health problem and not merely a truancy problem. The family had no telephone and so we drove over to the home without contacting the mother first. The house was run down and the garden was littered with old bicycles, shoes and boxes.' (5/11/79) Carol knocked at the front door and when there was no response we went round to the back. The door was opened by a small boy about four years of age, dressed in shorts and an undershirt. His sister, about eighteen months old, had a diaper, plastic pants and a soiled shirt. Both children had runny noses. Carol asked if their mother was home. The small boy went off and came back with his mother, who looked pale and tired.

Carol: I'm Carol Venning, the community health nurse, Mrs. Hertebois. The teachers are concerned because Jacqueline is missing so much school and they asked me to call as they thought she might have been sick. I'm the public health nurse and this (referring to the researcher) is another nurse who is with me today.

Mrs. Hertebois had the door open about one foot and we were standing on the porch. She stood with arms folded while the boy and girl clung to her legs.

Carol:	Jacqueline is in a special reading class and they feel she is making good progress and would like to keep her in it, but if she keeps missing school the class won't help.
Mrs. H.:	They come everyday - I send them - they're not in the house.
Carol:	Well, if you are sending them they are not arriving at school. Do you have any idea where they might be?
Mrs. H.:	No. They know no one. We have only been here three months. They go to school regularly.

Carol then asked whether the children could be taken to school by an older child or adult. As the oldest children were with their grandmother and Mrs. Hertebois had the two pre-schoolers there did not seem to be any possibility of this happening.

Mrs. H.:	I'd better keep them home.
Carol:	Now Mrs. Hertebois, I must tell you that if you don't send them to school you could be in trouble. Once they reach the age of Grade I children must go to school, or else their absence must be investigated.

Mrs. Hertebois moves back into the kitchen and Carol steps through the doorway. I decided to remain on the porch as I felt to enter might jeopardize the interaction at this stage.

Helping the Client Examine Alternative Actions

Mrs. H.:	If my kid is sick no teacher will tell me to send her to school. I've had about ten kids and no one tells me to send my kids if they are sick.
Carol:	No, Mrs. Hertebois. You are quite right. They shouldn't be in school if they are sick. But have they been sick?

Mrs. H.: Jacqueline was sick all last week and she was home.

Carol: That's fine. If she is sick that is where she should be.

Carol used the opportunity to reinforce Mrs. Hertebois decision and to assure her that she respects her right to make decisions related to her children's health. She was obviously still concerned about the two younger children going to school on their own (it was about ten blocks from the house).

Carol: Perhaps we can make Steven in Grade III responsible. I'll talk to him and you talk to him - would that be all right? If you are sending the girls to school we need to be sure they are arriving.

Mrs. H.: O.K.

Carol: May I come back and see you next week...you're home all the time with the children?

Mrs. H.: Yes.

Carol: Are you alone with them?

Mrs. Hertebois did not respond.

Carol: To look after them I mean?

Mrs. H.: Yes.

Carol: Is any particular time of the day better for me to come back?

No response.

Carol: I'll come and if it is an inconvenient time just tell me, and I'll come back another time.

Understanding Individual Differences

Carol remarked that Mrs. Hertebois seemed very suspicious of our visit. She compared the visit to one she had made recently to another native family, the McNamaras.

> This is not unusual - but only once was I refused admission and that was by Mr. McNamara when I went over. I wonder who has been hounding this lady. She probably has a social worker - and maybe welfare. Perhaps she's had children apprehended. When I went to the McNamara's I think I was the last straw. Moments after I got back to St. Frances two aunts were there demanding the children come out of class. The principal said only if the father came. Of course he didn't. At noon they went home and did not come back. The family took off for Smoky Lake. Then we heard the children had been apprehended in St. Paul. The sad thing is those children were bright and doing well in school.
>
> When I went inside the house, children everywhere. The new baby may have been the last straw for Mother. There was a small child pulling a bottle out of an old blanket. They apparently had plenty of clothes - Sister Maria from the Catholic Mission had taken over a load - and yet the children never came warmly dressed for school.
>
> With a family like that you just don't know where to begin. Yet for the children's sake you've got to find out what's going on.

In a later interview with the researcher Carol again referred to Mrs. Hertebois:

> Sometimes I wonder if these people are just bombarded with so many people coming to their doors, that they just automatically are hostile. Although I use ease of access [to the home] as an indicator, it is not my final [criteria but] it certainly has meaning. But then, I believe that everybody should be very skeptical about people coming to their house, and that I have an obligation to make them feel alright about me coming into their household. And if I don't do that, then I would wish that they would let me know. We enjoy such easy entrance that we get lazy and all we think we have to say is "I am a Health Nurse" and we are welcomed in. Really, we should say "This is who I am and this is why I would like to see you", before they let me in. So, with that woman I expect she had so many people, probably including social workers, police and a numerous people coming into her home that she was quite hostile. But I leave my final judgment until I have tried to build some kind of trust in mind. (29/2/80)

Carol left the way open for a return visit to Mrs. Hertebois. She showed an understanding of the pressures that clients are subjected to when visited by a proliferation of workers. It is noticeable that at the outset she did explain to Mrs. Hertebois who she was and the purpose of her visit. The tension did relax during the visit and she was able to enter the house although as she remarked "I was not invited in." I asked her why she had spoken of the legal implications of keeping the children home. "Often they [clients] simply do not know either their rights or obligations. Sometimes they make choices, which create problems for them, out of ignorance. I like to be sure they understand the consequences of their choice." To help another person grow is to help him care for something as someone apart from himself and it involves encouraging and assisting him to create areas of his own in which he is able to care (Mayeroff, 1971). In this situation Carol picked up Mrs. Hertebois' concern about caring for her sick child and commended the action she had taken. It was probably the only chance for positive input in the interview, but it was not overlooked.

After Carol moved to Redfield clinic she remarked:

> Behaviour like that [of Mrs. Hertebois] would take on a different significance here where you wouldn't expect people to be bombarded by a lot of [different agencies] coming into their homes. But in Greenfield, I think it's a daily occurrence. That's routine for them. Social workers, welfare officers, truancy officers. It's part of their life. (22/2/80)

In Chapter 4 the agency programmes for visiting mothers with new babies was described. In this area Carol's priorities coincided with those of the agency.

> When I go home visiting I usually put a priority on baby visits - unless there's something else pressing...such as that diphtheria case...I like to get out to a baby visit as soon as I get my referral because I feel that the first short while is probably the hardest time and they probably get most benefit from my visit at that time...so I try and do my baby visits pretty quickly once I get them. (4/10/79)

Developing a Profile of the Client

Carol took me with her to visit Brenda, a nineteen year old, with her first baby. From the birth notice it appeared that she was single. "I like to put single Mums on my priority list, because they frequently lack any support system of their own," Carol commented as we drove over. "This area is not typical of my district. There are some older houses here that people are buying that qualify for a government renovation grant". The house was older, square brick in design and had newly painted woodwork. We rang the doorbell and a young girl dressed in neat slacks and a blouse opened the door.

Carol: Are you Brenda?

Brenda: Yes

Carol: I'm the public health nurse. Did they tell you I'd be coming to see you? We visit all mothers with new babies.

At the outset Carol clarified the reason for her visit and her role. She did not, however, give Brenda her name. This was somewhat unusual, as she normally said "I am the public health nurse, Carol Venning". She also introduced me: "This is Peggy-Anne Field, she is a nurse-researcher who is observing what I do, do you mind if she comes in?" Brenda agreed and I explained the purpose of the study and obtained a consent to tape the interview. (5/10/79)

Brenda: I didn't expect you. They phoned today to remind me to go to class.

Carol: You had prenatal classes - at Greenfield? That's where I am from.

Brenda: No, Central.

Carol: They must have been full locally. Central clinic run extra classes to pick up the slack.

During this time we had all sat down. This initial conversation was used to establish rapport. The agency provides an outline of the areas to be discussed on this visit and once the social niceties have been exchanged, unless the client has an immediate problem, the visit will generally follow a predictable pattern, birth information, feeding, sleeping, help at home (support), return to work, birth control, the purpose of the clinics and the immunization schedule. The visits, I observed, ranged from twenty minutes to over an hour and a half, but the average appeared to be about thirty minutes.

Carol:	Now I need to ask you a few questions for my records. First, what is your surname - I call you Brenda because I could not read it.
Brenda:	Puff - but the baby is Ruzicke.
Carol:	You're living common-law?
Brenda:	Yes, we plan to be married in the spring....He asked me when I was pregnant, but for personal reasons I didn't want to then.
Carol:	How do you spell your surname?
Brenda:	P.U.F.F.
Carol:	I didn't know whether it was two "T's" or two "F's" or two "Z's" from the writing.

The notable thing about this whole exchange was that it all took place in the same businesslike manner, whether the information was on how to spell the surname or Brenda's marital status. Both nurse and client treated the whole conversation as an exchange of factual details. Brenda, Carol and I went to the bedroom to look at the baby, who was sleeping in a bassinet. She looked contented and well rounded. When we returned Brenda turned the conversation to feeding.

Brenda:	I've had her on Similac...but I am thinking of putting her on Carnation with extra sugar.
Carol:	For any particular reason?
Brenda:	My Mum fed all hers that way and she thought I should try.
Carol:	At clinic we usually recommend Similac for at least six months before a change unless the baby is not doing well

- but it's your choice what to do. We do think it better to stick to Similac.

Brenda: I asked my doctor and he said it was all right to change if I wanted.

Carol: It must be confusing with advice from your mother, your doctor and me...which would you prefer to do?

Brenda: Keep on Similac. It's easier and we hope to decorate the house, so if it's okay I'd rather use it because it takes less time. We have a home development grant: $10,000. This area was zoned residential and if you had an old house you could apply to the government for help to improve it. So now I want to start papering and painting before I go back to work part-time.

Carol enquired whether Brenda wanted to return to work or whether it was a financial necessity.

Brenda: Just part-time. I've got a job 4 - 11 three times a week. I don't need to work but I'd like a little extra money.

Brenda explained that she had been a secretary and had planned a business career but changed her plans when she found she was pregnant. Carol asked about baby sitting arrangements and Brenda indicated she had organized a baby sitter until her husband, Bert, got home from work.

> He helps a lot. Like the other evening he said, "You look tired. Give her to me and you have a sleep." Then I was able to cope again.

Carol checked out information on Brenda's pregnancy, labour and delivery. "Bert was with me when I had her." Birth control was discussed and Carol went over the immunization schedule and checked to see that Brenda had transport to get to clinic. We were offered tea, but declined as Carol had other visits to make.

In discussing the visit Carol identified the factors she had felt were important:

> On the first visit I always like to find out about the pregnancy, labour and delivery, and this Mum was fine. I also like to see how

> she's coping with feeding. What support system she has and whether its functioning - her boy friend was obviously helpful - and she has her Mum. Whether she's going back to work - and how she feels about it. Some Mums can't wait to get out of the house. She accepted a change in career plans - and was working for extra money not because she had to do it. She seemed relaxed and could look ahead to decorating the house, so her life was not overwhelmed by having a baby. Also she had made babysitting plans - so all in all I thought her a mature 19 years old, so different from some I see, and well able to care for the baby. Her only concern was advice on feeding - and basically she seems to know her own preferences. I don't feel concerned about her at all.

Ten days later Carol said to me in the lunchroom:

> Oh, by the way, do you remember Brenda, the young girl we visited? The one who seemed so competent? Well, the baby has a cold and she phoned to ask me to visit. She seemed somewhat reliant on her Mum's advice - I'm glad she called here.

When Carol evaluated the visit she had not expressed concern about the role of Brenda's mother, but she had noted conflicting advice on feeding when she spoke with Brenda.

> I think she must have seen my home visit as helpful. I did try to reinforce what she wanted to do.

For the community health nurse establishing a role with clients on an initial visit is critical. What occurs at the post partum visit may set the tone for subsequent client utilization of the services. Carol appears to have established her credibility with Brenda in this situation as evidenced by the telephone call that followed the initial visit. Also data obtained on this visit serves as the baseline for subsequent client care. This interview illustrates how Carol develops a profile of her client.

After Carol's move to Redfield clinic she commented:

> Baby visits are different here. The mothers know about the basics of feeding. You have to know more about child development, discipline, that sort of thing. The other day a Mother asked me what Similac contained. I'd certainly never been asked that in Greenfield!

....

> Another thing, here I phone to make an appointment. No more knocking on doors and walking in. Clients in this area would be very upset. They like to be prepared for the nurse. (23/2/80)

The Effect of Context on Visits

We went on two post partum visits from Redfield Clinic. Both mothers had been to University and were well read in the areas of baby and child care. The unusual names of the two girls in one family provoked a discussion on Greek mythology. This mother needed advice on rest and on leaving her house "less than perfect" for a week or two. The day before our visit she had called the clinic for help as she thought the baby was hungry and she was breastfeeding. Her husband had given the baby an early morning bottle and so she had had a long sleep and all seemed to be settled when we visited. During our visit the older girl, who was three, had been asked to go to her room until she felt able to talk nicely to people. When she returned, her Mother sat her on the couch beside her and put her arm around her. This was the basis for Carol's comment on discipline.

> Carol commented:
>
> She knows where to get help and seems able to use the advice she is given. She probably tends to be a perfectionist but she said, "I can leave the vacuuming for my husband on Saturday". So she does not seem to be compulsive. I am sure she will be all right. She has ways of disciplining the older child but seems to cope with her need for attention. I am not going to worry about her, she will call if she needs help.

The second visit was also brief Carol checked the obstetrical history, mother's support system and the baby's feeding. The client asked about birth control "I know I can't have the pill while nursing". She also asked about changes in the immunization schedule since having her first child. The client was again well informed and Carol felt that things seemed to be going smoothly. (26/2/80)

These visits confirmed Carol's observation on the different needs of mothers in the two areas. In Redfield the mothers were well read and had basic information. In Carol's words, "I'm starting well up from zero with these Mums and moving toward a positive health goal. It's less challenging, but it makes a pleasant change."

Much of Carol's work in the district showed evidence of a caring relationship. She encouraged her clients to make decisions, but limited contact does not allow time for building in-depth relationships and so reinforcement of behaviour had to be made whenever an opportunity presented itself. She looked for strengths in the clients and tried to build on these in the limited time she has with each individual. When she moved from Greenfield Clinic to Redfield she noted that the needs of the client and the information they requested had altered with the change in context.

Nurse-Client Conflict of Interest

When Carol was in Greenfield she experienced frustration with some clients. This appeared to be based on conflict between her goals for a client and the client's own value system. Dolores was one example of this; Diane provides another instance. Carol told me about Diane during an interview and later we tried several times to visit her, but could never find her home.

> She (Diane) was a Metis girl and she's 21 and this is her fifth child...she has only one child at home...the others are with child protection. Typically, this young lady has her children, usually by different fathers, she loves them to death when they're infants while they're totally dependent on her, and then as soon as they gain the least little bit of independence, I suppose...I don't even know...this is some kind of rejection of her and she...it's just total neglect, she forgets about them doesn't look after them and they're taken away from her. (29/9/79)

Carol speaks of Diane with respect, referring to her as "this young lady". It is obvious she is applying her theoretical background when she says "I suppose this is some kind of rejection of her", referring to the mother's reaction as the child becomes independent, but she is quick to qualify this as an assumption "I suppose...I don't even know."

She continues to describe Diane:

> Also, what goes on with her [is frustrating], these men beat her up all the time...I arrive at the door and she's had another horrible beating, won't charge them, she'll see them again and they'll beat her up again...and her life is so destructive...I haven't got anywhere with her as far as looking after herself in a better light. (29/9/79)

Carol's priority in nursing is "to help the individual to help themselves." When talking of herself she said "I have a secure sense of myself, meaning I like the way I am, I feel secure in what I believe, and I practice what I believe. I can carry on because I have a good sense of who I am." She also says she gets frustrated when "What I think may be a better way of life may not be for them...I get the feeling I want you to do it the quickest way, so that when it doesn't happen, especially if it's been a fairly trying day, I feel fairly frustrated." In this incident Carol does not accept Diane's lifestyle as the ultimate she can achieve and shows frustration when Diane shows no desire to change.

> [if she looks at herself in a better light] I think it would automatically make it better with her children...she's so down and

> out...so low...I guess that's just the way she's always been. Her mother was and her sisters all are.

Diane had a sister in Shipton school, but she rarely attended, Carol tried to contact her several times to find out where Diane was, but never found her in school. She was failing her year and this seemed to support Carol's comments related to the family members as a whole.

> It's like pulling teeth getting her [Diane] to do anything. Like "Diane bring your kids to clinic and then child protection won't perhaps take them." She only lives a few blocks from here and yet she won't bring them in. (Voice changes, sounds exasperated). I really have been so very unsuccessful with this little girl. I feel so badly for her...and she feels so badly about herself...she just can't seem to move from there right now.

Toward the end of this description Carol appears to assume a parent role in contrast to the adult-adult relationship she strives for with clients (Berne, 1971). She says, "I really have not been very successful with this little girl". She also resorts to threat to try to get Diane to the clinic. This contrasts with her efforts with Charles, where she encouraged him to take independent steps and did not use threats in relation to his failure to take his medication. Another source of frustration for Carol was that she had been unable to contact Diane's social worker and so there was no co-ordinated effort at working with the identified problems.

Conflict with Allied Professionals

Liaison with social workers was a source of friction for the district nurses. Social workers "think all information is confidential, so won't share things that would benefit the client." Carol was talking at lunch one day about another family she had been following.

> I was phoned by this B.Sc. student [in nursing] and she's working out of the Glenrose. She's been sent out to see the Miller family. Can you imagine? She breeds chihuahuas - dogs everywhere - you have to look at the chair before you sit down to get rid of the poop. But she's a good mother, loves the kids and brings them in for immunization. Phones me if she has problems. The student asked how I advised on hygiene! You can't begin - it's not important to her. If a kid is sick I can make suggestions and if she feels it's good for the kids she'll use it. I told the student to suggest that she give the child a bath and put some scent on her the day she is to have therapy - and that the teacher doesn't like the smell. She'll do it if she thinks the kid will suffer. You have to be blunt. She has four kids - all a bit retarded, but this one is the worst. I persuaded her to have a tubal ligation after the last one. But what a family to give a student! (Group, unsolicited, 6/11/79)

Despite the chaos in the surroundings Carol saw Mrs. Miller as a "good" mother, who cared about her children. She identified strengths that she could work with in relation to the family. She seemed perturbed that a student should be assigned to this family, yet the student worked successfully with Mrs. Miller she was able, through social services, to get a home help to work with Mrs. Miller to try to help her develop better homemaking skills. Carol was upset with the social worker's initial reaction when the student contacted her:

> She didn't want to send anyone in. She said the house was a mess, that Mrs. Miller didn't care. She didn't look at her strengths - she loves those children and will do anything if she thinks it will help them. The social worker only looked at the mess, not the good things. (21/11/79)

I asked Carol how the original contact with Mrs. Miller had been made, and found that the contact had been made by the previous nurse.

> A neighbour reported the children were being fed dog food. It wasn't quite like that. There was food on the table, and dog food. The children helped themselves when they were hungry and sometimes they took the dog food, but there was always plenty of human food too. It was just that it was all mixed up on the table.

Carol was able to accept Mrs. Miller, because despite her haphazard housekeeping, she saw her as accepting advice when it would benefit her children. One measure of being a "good mother" for Carol appears to be whether the children are brought to the clinic for immunization. Mrs. Miller took this step whereas Diane failed to make this move. Evidence of loving the child also appears important as Carol mentions this in assessing both Mrs. Miller's and Diane's behaviour.

Summary

In Carol's district many of the families came from the lower social economic segment of the population. Frequently they also had ethnic and cultural backgrounds that differed from her own. As she visited these families Carol showed respect for their ethnic and cultural differences. In her nursing she demonstrated a caring relationship and helped clients to identify problems and make decisions about their own lifestyles. She saw as important the fact that they could verbalize their problems and make decisions, rather than the type of decisions they made. She became frustrated with clients, whom she perceived as having a poor quality of life and who did not want to change their lifestyle. She accepted clients who rejected care, attempting to place their refusal in the social climate of their environment. When Carol moved from Greenfield to Redfield Clinic the effect of context on the nurse's behaviour became evident. One external factor that Carol viewed as impeding client care was the lack of co-operation amongst allied health professionals.

Carol's Schools

There were two elementary - junior high schools in Carol's district. Shipton was a public school with an enrolment of around 250 students and St. Frances was a separate school with approximately 300 students enrolled. Both schools had a high turnover in the student population and the frequency of English as a second language was also high. In watching the children in the playground it was evident that there was a real social mix, Caucasian, Asian, Black and Canadian Indian children were represented, and it would be difficult to select a minority group.

Carol commented on the difference between the two schools:

> The difficulty with Shipton is that the Principal thinks the internal services should be used, but sometimes the psychologist is so busy that by the time it's attended to the problem has gone so far it's insoluble. Another thing is that there are often no alternative placements for these children. By using Dr. Chivers [the medical officer attached to the clinic] I can often get attention for a problem fairly quickly.
>
> Now at St. Frances they use me more frequently to discuss the most appropriate service for a child. It's partly a difference in philosophy, but I think the fact that I've been there a year longer helps. (5/11/79)
>
> In Shipton only Miss Beardsill (the new Vice-Principal) and Mr. Montefiore really refer the children. Miss Beardsill tends to overuse me and I have to be careful these are not problems the school should solve itself. Mr. Montefiore really gives a good history - he's concerned.

The first morning we went to Shipton School we went to the office first to check the children who had transferred in from, or out to, other schools. The secretary had health histories from the parents and Carol said:

> I don't know what I would do without Anne's help. She keeps track of all children coming in, and when the parent fills out the school

> transfer she gives them a health record and a consent too. That way I catch up with many parents I'd never have caught up with otherwise. (5/11/79; repeated at a staff meeting, 26/2/80)

The nurses felt "we spend half our time in the schools, and half of that is clerical time." They also felt "every new programme affects the school time." Carol said:

> It's important to educate kids, go to classes, that's where health promotion comes in. But immunization is an agency priority, and you have to get your records to get on with that, so it comes first. (7/11/79)

After talking to the secretary, we went to the nurse's office and worked on records until recess. Then we went to the staff room. "You need to catch the teachers and be highly visible, otherwise you'll never get referrals." Mr. Montefiore [the counsellor] sat down and said:

> I have a boy I'd like you to see. He's a really disruptive child, active, upsets all the other children. I've had to isolate him at the front of the class. If I do that he does get on with some work. His parents are separated and he lives with his grandmother - father is in Calgary I think, he does something with trucks. He has a friend, Trevor, and the two had got hold of matches. There was a fire in the washroom, we are certain they were involved - but no proof we can use. Richard was in Marydale for awhile - it's in his cumulative record. He lacks friends. I think he has a constant need for attention and seeks it through negative behaviour.

Carol asked if he had seen the school psychologist and Mr. Montefiore said he felt the waiting period was too long and so Carol said she would talk to Richard and then visit his grandmother if necessary.

That morning Carol also discussed the Grade I students, with their teacher, who was in her first year of teaching. At one point the teacher voiced concern about a girl who frequently either missed school or was late.

Carol set out her role:

> If it's just a matter of being late, then it doesn't really fall

> into my jurisdiction. If it's a matter of clothes, or thinking they are late because they get themselves up and have no breakfast, then that's a health matter. I think you'd better speak to the mother first. If things don't improve, and in my experience that generally happens, talk to me again and we'll reassess the situation.

In this case the door was left open for further dialogue with the teacher. Carol explained to me later:

> Sometimes I'll go out to visit a family to make sure they know their rights. For example, the McNamaras, they were treaty Indians. Glen, the Grade III boy, said the little kids did not have shoes. I wanted to know if the family knew the available resources and their rights as treaty Indians.

> Here the problem was related to lack of adequate clothing, so this was an acceptable health related problem. Truancy, per se, is not a proper area for investigation by the nurse.

Developing a Profile of the Client

After talking to the Grade I teacher we went to get Richard from his classroom. After calling him out Carol introduced herself and told Richard I was a nurse-researcher and asked him if he minded if I sat in on the interview. He shrugged his shoulders in response. When we reached the nurse's room Carol and Richard sat down in two chairs facing each other.

> Carol: The teachers asked me to see you and talk to you. Do you know why?
>
> Richard: No.
>
> Carol: They are upset about your behaviour.
>
> Richard: I know.
>
> Carol: The teachers say you are disruptive in class. Do you know what that means?
>
> Richard: I disturb the other kids - talk to my friends and mess about.

Carol: Yes. Do you think that's true Richard - that you're disruptive in class?

Richard: (Nods his head).

Carol: Why are you disruptive?

Richard: Dunno.

Carol: What do the teachers expect you to do?

Richard: Keep quiet.

Carol: Why don't you do it?

Richard: Because...I'm always talking to my friend.

Carol: One friend?

Richard: No two, three - four!

Carol: Do you like coming to school?

Richard: Yeah!

Carol: No don't tell me that if you don't mean it - just because you want me to hear it. If you like school why are you disruptive.

Richard: (Silence). Don't know.

Carol established with Richard the reason why she was seeing him. He was quite cocky with his response and it was evident he knew what the problem was and what behaviour the teachers were upset about. He was an appealing boy, with dark hair and brown eyes. He looked at Carol when he responded but kicked his feet and avoided eye-contact when he said "Dunno" or was avoiding an answer.

Identifying Alternatives

Carol proceeded to ask Richard about his time at Marydale and he responded openly. They discussed his old school, which he said he preferred, and would like to go back to, but he answered "dunno", when asked whether he had more friends or preferred the teacher. He told Carol his Dad and Mum were divorced, but again responded "Dunno" to questions about his father's current whereabouts and how he was finding living with his Grandma. Finally Carol said:

Carol: Richard, Mr. Montefiore asked me to see you to see what could be done to help you. I'm wondering what you think. Do you think anything can be done?

Richard: I dunno.

Carol: You have no thoughts? I don't believe that. If you tell me what you think needs to be done it's more likely you can benefit. It disturbs me when you say "I don't know, I don't know, I don't know". So what I'm asking is that you think about what I'm saying.

Richard: You want me to say what I'm wanting to do - about what we're talking about [disturbing the class]?

Carol: Yes. You've got the chance to be involved - do you know what that means? If you won't be responsible other people may make decisions for you. The teachers are concerned about you, they think you're not happy here. I want you to think about it - and I'll see you next week. I'll be phoning your Gram and will tell her what we've talked about? Is that O.K.?

Richard: Yes.

Carol: You tell her I'll be contacting her when you go home for lunch.

I noticed that Carol always gives the children a choice before she phones their parents and asked her what she would do if they said "No". "I'd respect their decision, but I'd expect them to give me the reason why." In this situation after Carol has gathered information from Richard she does place the onus on him of making some decisions for himself. In assessing the interview Carol said:

> He appears cocky and confident, like many of the emotionally disturbed children I worked with in Ontario. And that's making an assumption on brief acquaintance. "I don't know", "I don't care".

> Yet when you face them with the facts they get near to tears. You can't help liking him - and he's certainly not dumb, he knows the score. (5/11/79)

After lunch Carol telephoned Richard's grandmother, who said she had to go out but would be back at 3:30 p.m. When we arrived and rang the bell, the door was opened promptly. The house was carpeted throughout and well furnished. Carol introduced herself, introduced me and asked if it would be all right if I visited with her. Mrs. Johnson raised no objection and I explained the nature of the study. Richard had told his grandmother that "a teacher" would call, he had also said he was disturbing the class and "I was told off for talking after my work was done." Mrs. Johnson was concerned that she might not have too much information "but if there's anything I can do...". Carol clarified the problem:

> As you know Richard's teachers are concerned about his behaviour and the fact he is learning nothing this term. I spoke to him this morning and got the impression he is not very happy at Shipton and would rather be back at Melton.
>
> Mrs. Johnson: His Dad didn't want him to move from Melton but when he had to leave him with me I said he had better go to Shipton. He'll heed his Dad and he'll heed Bob, my husband, but he won't heed me.

Mrs. Johnson said that at home Richard was constantly interrupting and demanding attention, particularly when she talked to someone else. We had evidence of that when he got home from school. He immediately interrupted the conversation "Grandma..." but had nothing else to say. His family had recently broken up and his younger brother was still in Marydale. Mrs. Johnson said, "They were both hyper-active I think it's called." Mrs. Johnson then produced Richard's report from the previous year which showed he had some trouble settling into school at first but that his academic performance was satisfactory by the end of the year.

Carol made arrangements for her telephone number to be given to Richard's father. Mrs. Johnson promised "My husband will take it round to his house tonight."

Carol asked Richard whether he'd like to go back to Melton. His face lit up "Yes". She asked him if she could talk to his Dad about the possibility. Grandmother said, "You would have to stay for lunch." Richard responded, "No - I don't want to do that. I can ride my bicycle." Grandmother: "When the snow comes?" Richard: That would be okay." Richard showed here that he could participate in decisions and was able to state his preferences, and Carol commented on this.

> I'm glad I went - his school report shows a similar behaviour pattern for last year. Perhaps, Mr. Montefoire can call Melton and find out how they handled the discipline problem. We now will have to wait for his father. Richard has given an indication of his preference - but I don't know if Grandma will agree. (5/11/79)

Goal Conflict

On leaving she said to Richard "I still want to see you next week. Monday's a holiday but I will be in later in the week."

Richard's father contacted Carol and appeared to have a good understanding of how he should work with Richard. He said: "I'll tell them at school, but sometimes they see it as interference, so you don't like to say too much right off the bat." When he talked to Miss Beardsill he was annoyed "She had a whole list of things - some three and four weeks old. I can deal with Richard as things arise, but it's no good hassling him for things that are over and done." Carol was sympathetic to his point of view. "I can understand why he is upset. Richard will probably not even recall what he did several weeks ago." I asked if she had discussed Richard's return to Melton and she said "Richard's Dad did not want to upset Grandma." Richard illustrates the complexity of the nurse's role as she tries to gather sufficient information, so that decisions made in school can be based on the best interests of all concerned. One wonders in this instance if Richard, after being encouraged to state his preference, understood the reason for the decision to leave him at Shipton. Carol says of her work:

> I'd like to get into the classrooms and really do some health promotion, but you're so busy dealing with the crises that have already occurred it's hard to get to any teaching. I seem to be patching and repairing families - we're always doing restoration - and immunizing and screening, prevention. I think we get little opportunity to do promotion at all.

A Family Conflict

The Catelli family illustrates the complex nature of the nurse's work and provides insight as to how Carol utilizes perspectives in her actions.

Gina was in Grade I at St. Frances. One morning she was late for school and her grandmother, Mrs. Catelli, called the secretary to explain her late arrival. In the course of the conversation Mrs. Catelli burst into tears and when Carol came to school the secretary asked her if she thought she could visit, as she felt there was a lot of tension in the home. Carol remarked, "An astute secretary refers more problems than the teachers." Carol had first seen the Catelli's in early September and I visited Mrs. Catelli with her when she went to get a dental consent signed in early October. Carol filled me in on the situation:

The Initial Biography

> I am going on a visit to the apartments over there. [Close by the clinic]. Usually I walk over. The situation is one where Mrs. Catelli, an Italian with old world values, has her daughter, Francesca, and granddaughter, Gina, with her. Francesca is not married and goes off with her boyfriend and the grandparents are left with Gina, who is now six. This worries them, not because they don't want to look after her, but because both work and that makes it difficult for them to plan. Mrs. Catelli was also very upset because she got home one night and found a strange man baby-sitting Gina. I saw Mrs. Catelli and I saw Francesca who agreed her behaviour was irresponsible and I want to see if things have improved. I need to get Francesca's signature on a dental care application form for Gina, as Francesca is not working she needs free care. (4/10/79)

The apartment block had an outside buzzer. We rang, Carol identified herself and Mrs. Catelli let us in. We walked upstairs and entered a clean, overly tidy apartment, with a great deal of heavy furniture. Ornaments and lace doilies were spread on every surface. There was little space in the living room. Carol introduced me to Mrs. Catelli and I explained the purpose of my visit. We were both asked to sit down in the living room.

Mrs. Catelli: I am glad you came. I am feeling so bad - so bad.

Carol: Well, how are things?

Mrs. Catelli: You really want to know?

Carol: Yes, I do.

Mrs. Catelli: You want the truth?

Carol: Yes, Mrs. Catelli, I want the truth.

Mrs. Catelli: Worse, much worse. Last weekend she stay out and she no come back until Tuesday. Whether she go to school or not I no know.

Now I have to drive Francesca to AVC and take Gina to school. My husband he get up to get Gina because I have to work. She walked home, but she stop to play with a friend and she never phone, my husband, he ready to call police. He ill for a week after - his pressure - you know. So he fetch Gina.

Carol: Do you let her play with friends?

Mrs. Catelli: Yes, if she call. Last week she go to Christine's and we say we are home and will get you. I like her to have friends. She have none here.

Carol: What has been happening with Francesca?

A tear trickled down Mrs. Catelli's check. Carol extended her hand and placed it on Mrs. Catelli's hand.

Mrs. Catelli: I feel so bad but I cannot cry.

The telephone rang and she got up to answer it.

Mrs. Catelli: (Returning) I am sorry to be so stupid.

Carol: That's all right Mrs. Catelli. I understand you are worried, you don't know what to do. I will talk to Francesca again and see what she has to say - but no promises.

Mrs. Catelli: She says I am sick in the head and should see a doctor. She makes me sick - but what can I do? I wish she were underground. God forgive me...but that's the way I feel.

Carol: Mrs. Catelli, if you had your choice what would you like to see happen?

Mrs. Catelli: Francesca to leave - but if I tell her to leave then Gina cries and says, "I don't want to leave Nonna and Grandpa." If I thought she would look after Gina.

Mrs. Catelli went on to explain that last summer her daughter from Italy had visited and wanted to take Gina back to Italy. She asked for guardianship of Gina. Francesa had objected, "No, she's my daughter." The situation in the home resulted in frequent arguments, over such things as Francesca not coming home and Mrs. Catelli having to take Gina to work; and Francesa not being allowed to borrow the car "One time she had it and she did not come back for a week. My husband and I we have to get to work." She described her embarrassment when, after getting Francesca accepted at NAIT to do hairdressing, she quit after a month. "I've always worked hard, take a pride in my job. Francesca, she no care." She is afraid Franscesa will embarrass her. "These people know me, know I work hard. I do not want them to see my daughter is no good." She then speaks of Gina, "Poor Gina...she gets so sad when her mother is not home. She say, "My Mom say she will come back - she lies to me."

Carol finds out Francesca will be home that evening and promises to call. She asks Mrs. Catelli to ask Francesca to sign the dental aid application form. As she leaves she says: "You see, you think of Francesca, you think of Gina, but you do not think of yourself and that is making you sick." (3/10/79)

In this interview Carol allowed Mrs. Catelli to express her feelings and sat quietly with her when she cried. She tried to determine what Mrs. Catelli would like to happen in this situation. This appeared to be for Francesca to leave and possibly for Mrs. Catelli herself to acquire guardianship of Gina. That Mrs. Catelli is torn between wanting to keep Gina and to have Francesca leave was evident. In evaluating the situation Carol said:

> You always see Gina playing alone - outside the apartment on the grass - or by herself in the house. She doesn't seem to have friends her own age.
>
> Francesca seems to understand the difference between her mother's values and hers, but she is unable to cope with them. She doesn't want Gina to grow up in the tight Italian values - she wants her to be Canadian - and this is hard. It is much of the source of conflict between her and her mother. She wants Gina to be independent, to walk to school and grandma won't let her.
>
> It's hard not to leave feeling totally sympathetic to Mrs. Catelli. Yet one has to remember Francesca has a side to her story too - and so does Gina. What would she really like to happen? Francesca's older sister is the perfect Italian daughter and I think she [Francesca] is made to feel this way. I think Francesca does behave irresponsibly and is unfair to her mother and I told

her that. She realizes it, but things have not improved. Gina feels the stress and certainly knows what's going on. Now I'll have to try and talk to Francesca and get her side of the story. (3/10/79)

Gina's Perspective

Carol called Francesca that night and she said she was concerned as Gina was upset and crying in school. So the next day (4/10/79) we went to St. Frances School to see Gina. Carol went to her office and placed two chairs close together. She went to fetch Gina and returned with a pale little girl, with dark brown hair and brown eyes. Her eyes looked big in her face and she did not smile. "Gina, this is a nurse, who is observing me as I work - do you mind if she stays?" Gina shook her head, climbed onto the chair and sat erect. Carol: "You're sure it won't bother you?" Gina again shook her head. Some social comments were exchanged about Gina's pretty sweater and a fleeting smile crossed her face, but she generally looked solemn. Carol told Gina why she had asked to see her:

Carol: Yesterday I was talking to your Mummy - I called her in the evening to arrange to see her as she is going to AVC now. She told me she thought you were unhappy in school, that you had been crying and I said I would talk to you at school today. Have you been crying?

Gina: Yes.

Carol: When were you crying?

Gina: I forget.

Carol: In school, at home?

Gina: Both in school and at home.

Carol: Can you tell me why you are crying?

Gina: Because Mrs. Steele gets mad at me when I make mistakes that I don't mean to make.

Carol: And how does that make you feel?

Gina: Horrible. I feel sad because I don't mean to make mistakes and she is mad.

Carol did not pursue Gina's reaction to Mrs. Steele any further. She asked her whether she told anyone when she cried, and Gina said she stayed in her room. Whenever the word "feel" came up, Gina responded with the word "sad". She used it five times in twenty minutes in the interview. She felt sad at home, because she had no toys, no friends and no one with whom she could play. Carol asked her if she could play with her friends and Gina responded "sometimes". Gina said her Grandma did not like her friends and it seemed she was talking of adults, particularly when she referred to Frank and Larry. Speaking of Frank she said:

> I like Frank. He babysat with me - but Grandma doesn't like him. She gets mad. He draws with me - and lets me colour. He's a friend but not Mum's boyfriend.

Gina again said, "At home nobody plays with me...I don't have any friends." When she had been asked to join a club by some other girls she had been too scared to walk along a plank, so she couldn't join. "I was sad." Carol then asks Gina what she would like to happen. "If you had a choice, where would you like to live?

Gina: With my Mummy and my Daddy.

Carol: You like your Daddy Gina?

Gina: Yes, he gives me presents. He gives me comic books and toys, but then my Mummy gets mad.

Carol: Gina, how do you feel when you think about living with your Mummy and Daddy?

Gina: Sad.

Carol: Sad?

Gina: Yes, they argue all the time...My Mummy and Daddy are divorced but my Daddy is kind to me.

Carol tries to probe further to ascertain Gina's feelings about the current situation at home, and finds Gina sees herself as responsible for the tension in the home.

Carol: Gina do you want to go on living with grandma or would you rather be alone with Mummy?

Gina: I don't like grandpa. He and Mummy fight. She needs the car for work and to go to see her boyfriends and Grandpa needs the car....

Carol: How do you feel about this Gina?

Gina: Responsible.

Carol: How do you feel responsible?

Gina: I don't know. It makes me feel sad and I want to cry.

Carol: How do you feel when Mummy goes off with her boyfriends?

Gina: My Mummy doesn't want me to tell...what she does with her boyfriends (eyes twinkle, brief smile).

Carol: That's fine with me, if Mummy doesn't want you to tell then I don't want you to feel you should...

During this interchange Carol appeared warm and friendly. She respected Gina's right to not answer when she saw it as a breach of her Mother's confidence.

Gina: I feel bad when Mummy is not there...I'm all alone.

Carol: I'll go and talk to your Mummy and your Grandma and tell them how you feel.

Gina: I love my Mummy...and my Grandma.

Carol: I'm sure you do...and they love you too.

Carol used the opportunity here to reassure Gina that she was loved. Gina lowers her eyes. Throughout the interview she had maintained eye contact with Carol except when she appeared uncomfortable. For example, when she said she did not like her grandfather and her "Mummy did not want her to tell." Also, when she spoke about her fear of walking the plank, she looked at the floor. Her answers were hesitant, but she appeared to know what she wanted to say. From my vantage point as an observer, Carol was patient, waiting for Gina's answers and never rushing her. At the end of the interview she told Gina what she proposed to do.

Carol:	I'll talk to your Mother and suggest she come to talk to your teacher. In the meantime I will keep in touch with you and have another talk with you. I think recess is over. Can you find your own way back to class?
Gina:	(Slides off chair). Yes.
Carol:	Your class is that way isn't it. (Points as she takes Gina to the door). You're sure you can find your way?
Gina:	Yes, I know.

After Gina left, Carol remarked:

Last time when I saw her at home, despite the stress, she was quite a bubbly little girl. She came and sat with me on the couch and she'd twinkle when she told me things. Today she's apathetic.

I asked Carol what Mrs. Steele, Gina's teacher, was like.

Carol:	Mrs. Steele is alert to the kids - but she's not warm. Last year in kindergarten Gina had two very warm people and she seemed very happy. I have heard before that Mrs. Steele slapped a child and that the parent had the child moved to another class - but I have no direct evidence of this. Francesca did say Gina had complained of being hit on the back of the head but she did not mention this today.
Researcher:	What do you plan to do?
Carol:	See Francesca first and encourage her to talk to the teacher. I think she should do this. I have to find

> out what her hours are at AVC and see if it is possible. In the meantime I can talk to Mr. Keene, the principal. He's pretty responsive to problems with the kids. Gina's bright and one has to be careful. She's capable of telling you what she thinks you should hear. She's obviously loyal to her mother, and contrary to grandma's assertion, wants to be with her. I shall tell Francesca that. At some point I'm going to have to talk to them altogether, but I needed to get Francesca's side of the story. [When I visited in September] Mrs. Catelli sat in the kitchen while we talked - and AVC is neutral ground, so I am just as glad to see Francesca there. (4/10/79)

Clarifying Data and Examining Possible Solutions

It was not until the following Tuesday (9/10/79) that Carol was able to meet with Francesca. We met her during lunchbreak in the cafeteria at Alberta Vocational College. Francesca spoke of her concerns about Gina being so unhappy in school and Carol confirmed that she had found Gina to be upset by Mrs. Steele's reprimands. Francesca said:

> She says she's a dummy. I'm worried because the first year of school is so important, it influences the next year. She doesn't want to go in the mornings.
>
> After some discussion about the situation Carol said to Francesca:
>
> I think it would be a good idea if you talked to Mrs. Steele about your concerns about Gina. How do you feel about that?
>
> Francesca: I do not want to interfere too soon because I want Gina to be independent, but she is so unhappy now. Will talking to her do any good?
>
> Carol: I think you have to talk to her first - then if it doesn't work you can go to the principal. He's very open in concerns regarding the children.
>
> Francesca: I could go next Monday. I'm on work experience that week and don't start until 3:00 p.m. I didn't want to jump in - Gina needs to stand on her own two feet.
>
> Carol: I think this may be beyond her...

Francesca: School should be fun at this age. It's their whole future.

Carol then told Francesca that Gina had said she was unhappy at home, that she had no friends. "She also mentioned one person, a man, who baby sat her, who she liked who her grandmother did not like."

Francesca: Frank! He's a neighbour, he's forty, lives in another apartment and is very good with her, but mother is suspicious. She says, "Why would a man that age look after a child?"

Carol: I can understand your mother's concern.

Francesca: He's really a nice guy - good to Gina and to me. He let's her have her friends in too. My mother won't let me have boyfriends over, so I go out. She won't let Gina have her friends - and she has no choice.

Francesca told Carol her mother doesn't like any of her friends. When she came over to AVC for lunch and met the instructor she said "How does she do - is she dumb?" When the instructor said Francesca was making 92% her mother asked how much she had paid him to say that. Francesca then described how her mother waited for class to end and when Francesca did not come out at the expected time demanded an explanation "Twenty-eight years old - and she still treats me like a child!"

Carol: Francesca, you know that what your mother would really like is custody of Gina. How do you feel about this?

Francesca: She's my child. I love her and if it would be better for her I would say, yes. But she would be tied down. She would never be independent.

....

Carol: There's one thing that puzzled me - Gina talked about her father.

Francesca: Oh yes, that would be John. I lived with him for a few months and he really got on with Gina. She was upset when we broke off - but it just didn't work.

Now if he phones her she's not allowed to talk to him - my mother just hangs up on him.

Carol: Your mother would really like you to move out, but she's afraid you won't look after Gina.

Francesca says her mother thinks she won't stay home, but if she lived in her own place she could have her friends in to visit. She has money saved toward a deposit on the apartment. Now she says, "I'm taking this course, then I can get a job. I need to move out for Gina, she's most important to me."

A Conflict Situation

The next week Carol came into lunch at the clinic and sat down next to me.

> You remember Francesca was to see Mrs. Steele? I felt so angry with Mrs. Steele today. She said, "The mother wanted me to give extra attention to Gina. I can't single out a child for extra attention. I'm not going to have a mother tell me what to do in my class. I said, "Mrs. Steele, I'm sure Francesca did not expect you to treat Gina differently from the other children. But with her home situation she needs a little more praise - she has to be corrected, but perhaps gently." Hasn't the woman any feelings! (19/10/79)

Carol's reaction to Mrs. Steele is similar to her response to the social worker, who failed to see any positive strengths in Mrs. Miller. Her own concern for her clients tends to make her intolerant of other individuals who do not share these concerns.

A few weeks later Carol told me she had seen Gina and that she seemed happier. She again spoke of Mrs. Steele's reaction to the children.

> She [Gina] did come out and say she liked Mrs. Ionescu better than Mrs. Steele. Mrs. Ionescu is more responsive to children. She'll say "Would you see so-and-so, there seems to be a problem and I

> can't figure it out" whereas Mrs. Steele will say "That child's out to lunch." She really is unresponsive to need. (5/11/79)

Gina did see the school counsellor, Father Clark, on a regular basis. Following Carol's talk with Mrs. Steele she seemed to settle better at school. Just as this problem seemed to resolve itself a new one arose.

> I saw Francesca today, she was fetching Gina home from school. I was just about to say something about Gina, when I noticed Francesca looked awful. I said "You don't look well, how are you feeling?" It seems she had been in the hospital with an infection and that she has a growth in her uterus and will have to have surgery. In the meantime she can't work. She was upset about AVC - but they told her not to worry she could get her last week with the next class. Gina is happier - maybe it's having Francesca home.
>
> Francesca was quite flip - and I said "You must be concerned" and a tear trickled down her cheek - so I said "Would you like me to come over so we can talk?" She said "Yes". Poor Francesca, poor Mrs. Catelli, just when things looked as if they had a chance of working out. (14/11/79)

Gathering, Extracting and Sharing Information

Carol did not get back to see Francesca before she left Greenfield Clinic. I asked her how she felt about her work with the family and what she felt she had achieved. In analyzing her role with the Catelli family Carol saw her most important function to be facilitator of communication among the family members, and between Gina, Francesca and the school. "I can't say I was particularly successful in finding a solution, but it seemed to me no one had a good appreciation of what the other person was feeling." She felt that she had been able to share her perception of this with each member of the family.

> Grandmother's anxiety was so obvious and I don't know if Francesca appreciated how anxious she really was. Francesca's mother does not appreciate what she is going through; communication between them was really poor. I really believe Francesca almost feels that

> nobody is her friend, or she is lacking in a friend, and she --- I think she identified with me. I was her age. I understood. "Somebody finally could help me out. I need some help, and I am not getting it very easily." So, I think I provided that kind of help for her. Gina needed some extra attention in school and Francesca tried to talk to the teacher on my suggestion, which I am glad of, but that teacher just wasn't very receptive to her or the way she presented her effort. And, I added on to that say "This is the reason. This is what's happening. And this is why I think that Gina might be needing extra attention." So that Mrs. Steele could then say, "Oh, well that makes more sense. I will get Father Clark to see her when he comes into the classroom!" So, for a short term, Gina needed a little bit of extra comforting and attention. So just interpreting, or expanding the communication that Francesca, in fact, had initiated, when she spoke to the teacher. I think [Francesca] gets tired of being rejected or tired of not being heard. As long as she knew and was reassured by me that, "Go do it, and I'll make sure that something happens, but I want you to do it first." I think that's important. Then she knows she has the background, and that she...[made the move] even if she doesn't feel that she got very far. So, I think that those two things were really important there.

I asked Carol how she felt about leaving Greenfield when she knew Francesca was suffering another crisis.

> Just terrible! I felt that she was going into the hospital and she was in real crisis with that tumor, and in fact, even before leaving the district I couldn't get a hold of her. I didn't know what had happened, whether she was O.K., whether her surgery in fact had happened, or what. I met her in the hall and this all came out. So, for 15 brief minutes I was trying to...give her some support and some comfort. I needed to see her at home. Then - boom - I was gone - there wasn't time to go back and "wrap up". I was not feeling so good about that. The nurse now can pick it up but it's going to take some time to build up a relationship. (28/12/80)

This family illustrates the complexity of data gathering in community health nursing. Carol had to piece together the stories presented by Mrs. Catelli, Francesca and Gina to begin to understand the family dynamics. Polya (1957) speaks of problems-to-solve and problems-to-find. He says the object of a problem-to-find is to identify the unknown of the problem. In Carol's view this is what happpens when you work with a family. You gather, extract and share information with family members. You reflect on your observations with the client(s). Then you say to the client this is how it appears to be, how would you like it to be? What lies in between is the problem and once that is identified you can review the alternatives (27/2/80). With the Catellis you can see Carol acting in a manner compatible with this perspective as she works with the members of the family.

A Conflict with Carol's Perspective

When Carol was transferred the Catelli family lost their support system and when my observation ended in February the new nurse in Carol's district had not talked to Gina at St. Frances or contacted the family. Carol's comment that much of the family care was patching and repairing was well illustrated in the case of the Catelli's, after five months Gina may have been happier in school, but the basic problems of the family remained unsolved. The work she did conflicts with her belief that the focus of her nursing should be on health promotion. The role of the nurse in relation to the school extends beyond its boundaries and reaches from the student to the family as a whole.

Caring comes from the Anglo-Saxon word caru which means sorrow and anguish. Carol's involvement with her clients leads her to say: "I feel so badly for them." Sometimes she has days when she can no longer go out visiting "I'm so drained, I'm no good to them or to myself." I asked her if she took her nursing home with her at night.

> Not chronically so. I can feel very frustrated and take that home. More often its a feeling of sadness, like I am overwhelmed by people's situations and how I can't see them getting out of it or having a happier life and that makes me sad for these people.

I asked Carol how she coped with stresses in the system and she told me that some days she had to return to the clinic to get away from complex family situations. She would use this time to catch up on her paperwork. Carol also used colleagues (including the mental health consultant) and her husband to ventilate her problems.

Assessment of the Situation

In school the nurses also get called on to do first aid although most first aid appears to be the band aid variety which teachers can handle effectively without the nurse's help. When we were at St. Frances the teachers' aide in kindergarten came to the office to ask Carol to check a festered hand that she had treated that morning. Darren McNamara, a five year old, had arrived with a cut that was obviously infected. He was always brought to school by his brother, Glen, and was a regular attender. His home circumstances gave rise to concern as his mother appeared barely able to cope with her many children. Carol went to see Darren and then spoke to the aide.

> You did an excellent job. It's clean and you applied antiseptic. There doesn't seem to be anything in the cut. You're probably better at first aid than I am having brought up a family of your own. Would you watch it and keep it clean and tell me if it starts to fester again? I am told Mother can barely cope at home - so if it's to heal it will probably need care in school.

This approach contrasts with Carol's usual one as normally she believed in making parents responsible for their child's care. At Shipton when ten year old Sharon had come in with a grazed hand she had told me:

> I believe it's important that children go home and talk to their mothers and that they understand what is happening to them. I try

to explain at their level and get them to tell their Mums.

As she attended to Sharon's cut, she explained what was happening:

> Now the first thing I want you to do is go and wash the hand at the sink (child washes). Good! Now it's nice and clean with no dirt. Now we'll put some antiseptic on it. It's not too deep, mainly a scrape with a cut right here. We'll put a band aid on that. Tell your Mum to take it off and have a look. You don't want to leave the band aid too long, it heals better in the air. Now be sure and tell your Mum what I did - wash and antiseptic.
>
> Sharon: I'll tell her when I go home.

A Conflict Situation

Sometimes Carol's belief that children and parents should have responsibility for their care, leads her into conflict situations. She had difficulty with a supply teacher who wanted her to remove a sliver from a child's hand. She felt it was better left until the child went home. She was not really sure if there was a sliver and thought the hand "needed to soak, for I don't know how long...half an hour, to try and loosen it up, then someone could dig away and see if it was there." Her second consideration was "She wasn't in pain." "She was going home in 10 minutes, so my route is to inform the Mom and get her to do it when she gets home." She felt the teacher would not listen to her explanation, so finally said, "It wasn't in my job description." "If you want a reason Buster! this is it. He wasn't willing to listen to my other reason - and if nothing else I wanted to cut off his rudeness, which I believe he was being at that point, to me."

Carol again is upset by a situation in which another professional held a view of client needs that differed from her own. Here she feels she gave a rational explanation but saw the supply teacher's response as rudeness, which she refused to tolerate.

She added:

> Probably under any circumstances, if the child was not in pain, I would in fact not remove the sliver because [that means] breaking the skin and legally I could introduce infection. I doubt whether I would. Primarily though it's something that could best be done at home.

Obviously in making her decisions she does consider what she knows about the competence of the parents and her response to Darren's needs illustrates this.

Developing Responsibility for Health Care

Another area of school responsiblity is immunization and health screening for vision and hearing. Just prior to my week with Carol in November she had completed T.B. testing in Shipton School and was following up children who had a positive Mantoux or where there was a family history of tuberculosis. Colleen was a Métis girl, who was 12 years old. There was a family history of tuberculosis, as Colleen had had a positive Mantoux previously she needed to have a chest x-ray.

> Carol: Colleen, do you remember that test I gave your brother last week? You had it when you were up North didn't you? Do you remember having a red arm?
>
> Colleen: From here to here (indicates area on forearm).
>
> Carol: Yes, because of that we won't do the test again and give you a sore arm. Your response showed you had been in contact with T.B. and that you could have germs in your body. So you have to have a chest x-ray so we know if you are well. Trouble is with T.B. you don't feel ill, so we need the x-ray to be sure you're O.K. Now I want you to tell your Mum that you have to go for x-ray and tell her why. Do you remember what I said?
>
> Colleen: Because my arm was red I could have bugs in my chest and an x-ray will find out.

Carol: Good. Now tell your Mum. She works doesn't she?

Colleen: (Shakes her head). Not in the day.

Carol: You don't have a phone do you?

Colleen: (Shakes her head).

Carol: Well, tell your Mum I'll call tomorrow afternoon and [in the meantime] you can tell her what we talked about.

In talking to Colleen, Carol explains what is happening, checks to see she has understood and then asks her to tell her mother. She follows through on her belief that it is important for children to understand what is happening and to talk to their mother about the problem. When we visited Colleen's mother the next day she had received the message and did take her daughter to the hospital clinic to get her x-ray taken at the end of the week.

The Effect of Context on Priorities

In Grade VII health periodicals were carried out. These were not always seen as useful by the nurses. Some felt that the contacts were so rushed nothing really was achieved. In a staff meeting at Redfield Clinic (26/2/80) one nurse said "I have a time-bind. I feel what I can offer in [the periodicals] may not be worthwhile." Carol felt they had a spin-off value.

> I found my junior-high visits from students shot up after I'd done the periodics, and also after maturation classes. Talking to teachers and principals did not have the same effect...it wasn't really until March the kids saw me and then they came when they knew who I was. At Shipton I had to get going early [on immunization] - otherwise the students would transfer out and the next nurse would have to get records - and by the time that was done the school year was over.

> When I took over St. Anne's (in Redfield) the nurse had not started immunization. I was shocked! Then I realized most of the kids were up to date, the situation was stable and it was not urgent. (27/2/80)

Carol found that several things changed when she moved from one area to the other. The context of the work certainly influenced the priorities when she began to organize her school programme.

> I always allocate a regular time to spend in school, but if I need to I can do home visits or go to the office to catch up on things. Of course when I do my periodics I just book the time solid - but generally there's flex. (5/11/79)

Conflict with Administrative Priorities

Time allocated for school work was not inviolate as far as Carol was concerned. She was concerned about the amount of paperwork. "It's frustrating, there must be a better way." Yet I never saw her bogged down by it and she spent less time on records, while I was with her, than any other nurse I observed. I spent one afternoon with Carol when she did periodic examinations at her new school. This involved vision testing and checking for scoliosis in the girls, which was a new task that had recently been added to the school program. Carol said, "It came across it was optional, but optional to the degree that nurses feel they have to do it." At the staff meeting I attended I got the impression the nurses saw it as a worthwhile project, but felt it had been imposed on them too late in the year. At the staff meeting Carol said, "At least introduce it in September. I plan my year, sort of. I have other things planned, we have no extra help." The screening itself did not take much time, but letters had to be sent to parents, and a report on each child was filled out and sent to Central clinic for research purposes. Once again, it was the clerical load, the non-nursing duties, that were increased. "Clerical takes half-a-day. I'd like to do health education and if there was more time I'd give it priority. We're always doing restoration and prevention - never health promotion."

I asked Carol what she meant by health promotion.

> Giving clients information about health so that they can be as healthy as possible. It certainly has nothing to do with disease at all. You would be hitting a population that hopefully is disease free. Prevention is hooked in with disease - like immunization. When I talk to prenatal couples I am promoting elements of a lifestyle that go beyond the prenatal or even the post partum period - I hope they will be conscious of good nutrition for life. (22/2/80)

With her concern for optimizing people's lifestyles it is not surprising to find Carol places a priority on health promotion. Yet the constraints of the organized programmes and perceived agency priorities do inhibit her ability to implement her values in practice.

Health Promotion and Anticipatory Guidance

The afternoon I was at St. Anne's, Carol saw only the girls, as she was checking for scoliosis. She took this opportunity to ask each one about their menstruation, if their periods had started, or if not if they knew what to expect.

Carol: Have you started your period yet?

Barbara: No.

Carol: Has your mother talked to you about it?

Barbara: Yes.

Carol: Do you know what will happen?

Barbara: Yeah...my pants may feel wet or be stained.

Carol: Do you know what to do?

Barbara: Yeah, go to the washroom and use a kleenex until I go home at lunch.

Carol: Do you understand what is happening?

Barbara: Sort of...I make an egg.

Carol: Yes. When an egg is produced, the lining of the womb builds up, like a nest, if the egg is not fertilized the lining that has built up is shed and that is when you see blood. If at any time you start to feel you can't go to school or feel "yucky" tell your Mum, because that's not normal and you need to talk to her about that.

Respect for the Individual

Carol tried to keep her explanation simple at a level she felt Barbara could follow. She then explained about scoliosis testing. Barbara had no undershirt, so was reluctant to take off her heavy sweater. Carol found a sling and showed her how to use it as a bikini top.

Carol: You put that on and I'll not look until you're ready (turned her back).

Barbara: Yoo hoo.

Carol: Ready now. Good!

Carol demonstrated her respect for Barbara as a person. She believes respect is important "For if you don't respect them they are not going to respect you - and I think you have to have respect to be credible." All her screening visits followed a similar pattern to her interaction with Barbara that afternoon. Normally she told the girls that their backs were all right, with one girl she forgot and Riva asked if there was anything wrong with her back. Carol responded "No there isn't, I'm sorry, I meant to tell you." Her apology again demonstrates her respect for the other person.

Acceptance of Individual Differences

Carol found the school and the knowledge level of the students at St. Anne's very different from that of the students at Shipton and St. Frances.

> Somehow it seems as if the children are more stable - and I suppose that's true, few broken homes or single parents. I guess the parents have the energy to be concerned about health. Nearly all the girls here know about menstruation and what to do. The students too are more open. Before many children were evasive, would not give answers, they were probably taught by their parents, who were afraid of social work and child protection!

Carol was able to look at the family picture and recognize that social and economic problems do not leave energy for concerns about health. She did not condemn the parents as uncaring but identified the behaviour as a product of the circumstances.

Establishing the Role of the Nurse

At St. Anne's, when she transferred, she left the immunizations and did some classroom teaching and was now completing the periodics. "Now, when I do immunizations they already know me and it's not just zap! the nurse gives the needle." She sees herself here as trying to establish rapport with the children and at the same time establish her role with them. This is in keeping with an earlier concern she expressed. "I am not sure that the public know what we do - and sometimes I'm not sure if all of us know what is expected of us either."

Here she tries to establish her role beyond the one some children obviously hold when they come up to the nurse in the corridor and say, "Oh, you're the lady who gives the needle."

Summary

The description of Carol's work in the school has illustrated the complexity of problems the nurse must deal with in her contact with students and their families. In forming a biography of a client Carol talked with teachers, the child himself/herself and with members of the family. She identified the client's view of the problem and helped them to view alternative courses of action. Carol's consideration of cultural factors and her assessment of strengths and weaknesses amongst families was shown. Situations where conflict occurred were illustrated, these included conflicts between the nurse and teacher and between Carol's goals and agency priorities. Carol was shown as she implemented her perspective as it related to decision making, developing responsibility for health care, health promotion, and establishing her role. Her respect for the individual was evident as she interacted with her clients. The effect of context on her role was identified as she moved from Greenfield to Redfield Clinic.

Clinic

In Chapter 4 the function of the nurse in the clinic was described. First I asked Carol several questions to get her view of the clinic. I asked Carol what she looked for as she talked with a mother and child in clinic, then how she coped with the time limit on visits.

> Very much how they interact with the infant. Uh...Far more than even the appearance of the child. Lots of babies are quite dirty, or you know, aren't at a good level of cleanliness, yet, mother is obviously really bonded well with that child. How she holds that baby, how she talks to the child. Her gestures, or how she, even in disciplining, where she chooses to give the kid a tap or the tone of voice she uses when she is disciplining, as well as the type of discipline that she uses. How relaxed they are with the child. For example, the Perrin family. They are very poor and live in just a shack but the hair on those kids was always, always shiny and clean. The clothes may be very old to begin with, but their hair was always clean. And kids can mess up their faces and their hands, but it takes a lot more to dirty up their hair. [I look] very much at the interaction of the parent to the child, and how naturally that comes. If it looks stilted or put on, then I would be suspect, but if it looks like she does it everyday, that means a lot to me.

> I used to get frustrated and think if I had more time I could accomplish miracles. Now I view it as the time I have I must make most useful. I don't have a concrete goal, she's here - she must be there in ten minutes...I don't work that way. If I'm conscientious about my belief in public health, if I can in fact help this woman make one step toward an independent decision I've done my job. That goal is not "now the rash is gone", but has she some more knowledge to make a decision on how to get rid of the rash.

In clinic Carol goes out to the desk to collect the client's record, glances at it briefly, then calls the client into her office. She says, "I'm Carol Venning, I'm the nurse who will be seeing you today." She then greets the child, "Well, how are you, Sammy" and says to the Mother, "How have things been going for you?" This appears to be almost a ritual. Usually at this point she introduced me. I explained the project and asked if I might tape the session. If the mother indicated that things had not gone well, or that there was a problem, then this was discussed. Otherwise Carol would check the chart and from the age of the child determine the focus of the visit.

In speaking of her role in clinic Carol said:

> Talking about prevention first of all, we try to be anticipatory. Stress and crisis will occur, so we try to give information to help [the clients] alleviate stress or to change their lifestyles to prevent it if possible. (29/10/79)

The Preventive Role

Mrs. Rolands was a registered nurse, who originally came from Hong Kong. She brought her six month old son, Owen, for his third immunization. Carol noticed that the nurse who had seen Owen the previous visit had noted that his legs appeared to be bowed. This was her first contact with the family.

Carol:	I'm not sure how much you know about what's gone on here before, so I'll just go through it. There was some concern about Owen's right leg...that it appeared bowed. At that time you had recently seen the doctor and he wasn't concerned.
Mother:	No, no.
Carol:	Have you gone back to him since then?
Mother:	Yes, last time I go back about two months ago, just after the clinic. I go back now soon.
Carol:	Is the doctor concerned, or is he...?
Mother:	He didn't say anything?
Carol:	Are you concerned?
Mother:	A little (laugh)...

Carol examined the leg with the mother, who was concerned Owen might roll off the table. Carol stood him up, commenting on his behaviour "Push - this one, eh! I see a little bowing there. Do you notice it getting less and less?"

Mother: Yeah.

Carol: Or is it about the same?

Mother: I think it's less now.

Carol: It's hard for me to know because it's the first time I've seen Owen...It's not in my experience of seeing bow legs an exaggerated bow. It's quite slight.

Mother: I think most of the baby have a little bowed leg.

Carol: Yes. The only thing would be when he starts to walk and put his weight on it...watch to see if it affects his walking or his gait...I don't think it's of concern, it seems quite slight to me, but I'll put a note on for the nurse to check when he starts to walk.

In this sequence Carol checked out the Mother's concern about the problem, using both theoretical and practical knowledge she assesses the situation, reassures the Mother and outlines the plan for follow-up.

Anticipatory Guidance

The next phase of the visit involved doing a Denver Developmental Test on Owen. She explains this to Mrs. Rolands:

> This is called the Denver Developmental Assessment and when the baby comes in, we like to take his height and weight, as you know, and that's where we see physically that he's growing, and this tool we use to follow his gross motor development, which is his sitting and crawling, his language, his fine motor, how he manipulates his fingers, and his personal-social, which in a baby is how he responds to his mother.... We usually do this at two months, now, at a year and maybe three years as well. It helps us to pick up whether a child is progressing normally....it also gives you a good idea of where your kid is at, what he's going to do next, so you can anticipate it, particularly in the gross motor area.

Carol then turns her attention to Owen, talking to him as she starts testing. Her conversation contains asides to the mother.

Carol: Let's see what you should be doing, eh Owen? He sure is into things (baby reaching out for objects on desk). Everything's interesting isn't it? There's some things I can ask you about....is he feeding himself...like a cracker?

Mother: He try a cracker. He always try to grab a cracker in the morning - but he so messy - usually when I spoon feed he try to grab it.

Carol: Will he take a baby biscuit?

Mother: He can't hold so good.

Carol: I see, not quite yet, eh?

In this sequence Carol checks out Owen's behaviour. She verifies information with a secondary probe question when the mother's response is unclear. When Carol was testing Owen's ability to sit or stand she pointed out the baby's progress to the mother.

Carol: He sits well, he's bent over yet, but as he gains more strength in his back he will be able to sit up staight and maintain his balance. He's got really good control of his head. You say he's crawling?

Mother: You have to put things away from him.

Carol: To make him go?

Mother demonstrates Owen's ability to crawl for Carol and is delighted with his efforts. "Good bebee - oh good bebee." She picks him up and hugs him. Carol uses the opportunity to provide guidance.

Carol: Very soon, it sounds as if he will be pulling himself up. He'll hold on to things, for example the coffee table.

Mother: He's doing that on the coffee table - he stood right up in front of it.

Carol: Something to be particularly mindful of at this age, is the fact that he may start to pull himself up on things that may be unsteady and that may fall over. And, of course, there's a whole new world once he can reach and once he gets standing up by something. He really looks as if he's right in line here as far as his gross motor - because he's sitting well, standing well. (To Owen) Is that good? Is that good? Big smile! (To Mother) Now as far as his speech, is he starting to say "Da!Da!Da?"

Mother: Oh, starting to squeak. He make three or five different sounds squeaking.

Carol explores whether the sounds are imitation of mother's noises. She provides some anticipatory guidance on language development. The baby crawls on the floor, and Mother says, "Bebee, not over there - yeh", as he moves toward the supply cart with vaccines and syringes. The whole interview seems friendly and relaxed. When Carol works with Owen she rewards his efforts saying, "Good for you, yes, good for you." They discuss diet, Mrs. Roland is somewhat concerned because Owen does not like juice, but Carol reassures her, "I find many of the Mums say that orange juice is just a little too acidic, apple juice is easier for them to drink, so I'm not worried. It sounds like his diet is really good, as long as you've no concerns about it." Here Carol leaves it open for the Mother to pursue nutrition further if she wishes but she responds "No! No." They discuss immunization and Carol checks that Owen did not have a reaction to the last visit. Mrs. Roland then has a thought about nutrition.

Mother: I can start him on 2% for now, can't I?

Carol: That's certainly an alternative...um.

Mother: I put half 2% and half Enfalac....

Carol: You'd like to try it that way?...We suggest Formula for six months, which he is...and after that whole milk or 2% is quite acceptable. I think introducing it gradually is a good way, as you are doing, but don't be surprised if there are some bowel or digestive changes.

Mother: I've tried it two days and it's clear so far.

Carol: Then it probably isn't going to cause any trouble.

Conflict with Agency Policy

Feeding advice creates some problems for the nurses. Agency policy supports whole milk until a year of age, but most of the nurses feel that if the mother has made the switch to 2% and all is well, it is better not to push the issue, particularly if it is the mother's first baby. They feel it more of a risk to undermine her confidence than to leave the child on 2%. Carol is quite willing to say to mothers, "This is agency policy, and this is what I believe" and leave them to make a choice, if she does not agree that a policy is useful in a particular instance.

Carol checks whether Mrs. Roland is working and finds she is part-time. She says also that she is taking courses to become a design artist, she thinks she would prefer this to nursing as she could work at home. In the course of the conversation babysitters were mentioned and it appeared her husband had been on sick leave, so this had not presented any problem. Mrs. Roland explained her understanding of and feelings about her husband's illness. Immunization followed, when the child cried his mother picked him up and cuddled him and he soothed quickly.

Carol said:

> Unless you want to see us again for any reason you don't have to bring Owen back until he's a year old. Then it will be time for his measles shot. I've written an approximate date on your card to remind you. As he hasn't been fussy before I don't think he should be tonight.

Evaluating the Family

In evaluating the visit Carol outlined several factors she thought had been important. First, checking Owen's leg and also Mrs. Roland's perspective on the problem. She felt that the mother was comfortable with the situation. Then the Denver had to be assessed, "I think when they [the children] come in you get a feel for where the child is at right away - but using the Denver helps you interest the mothers in the child's development". It also provides a chance for them "to anticipate what their child will be doing". Another thing Carol said was, "At the end of the visit I always like to check the family thing." When Mrs. Roland mentioned the illness, "I wanted to see if it was a worry for her, but she said, 'I looked it up in the book', and she seemed to feel alright about it." Carol also likes to see how they are feeling as a mother, "It was interesting to note she's contemplating a second career, so she can stay at home."

Carol felt "the baby is fine! There is nothing I'm going to star or underline in this visit." Starring and underlining are used to identify points that need to be checked by the nurse in subsequent visits. Her final observation was related to the mother herself:

> Mum seems to be doing well as a Mother and feeling good about the whole thing - she handled the baby calmly - talked to her infant a lot, particularly during the Denver, when he did things, when he was crawling over to the cart. She was proud to say "he's doing this" and "Yes, he can do that." She's really quite involved in being a mother, so I think she's handling it all right. I found her quite fine.

It was obvious from this that Carol had put emphasis on evaluating the mother-child interaction, which she had indicated that she used as a criteria of family well-being. She judged that the interaction between Owen and his mother showed evidence of a secure relationship and that the child and his mother were both doing fine.

Obtaining a Client Profile

With Mrs. Harris, although Rachel was her fourth child, she reviewed the Denver Development test and its purpose. Rachel who was five weeks old, was crying loudly.

Mother: There! There!

Carol: Is she hungry, or...?

Mother: I think she is, she was asleep and I woke her and she thinks it's feeding time (laughs).

Carol: Are you breast feeding?

Mother: Yes.

Carol: Feel free to if you want, but if not it's okay too.

Mother: (Laughs). (Mother uses a rattle to distract Rachel, who settles down). No, she'll probably be all right.

Here Carol responds to Rachel's need and gives the mother the opportunity to nurse her if she wishes. She makes it clear that this is the mother's choice, so she does not feel obligated to feed Rachel at this time.

Following this exchange Carol obtains a prenatal and intranatal history. Then a discussion on infant feeding occurred in which Carol ascertained Mrs. Harris's knowledge level.

Carol: What kind of feeding pattern do you usually follow?

Mother: Almost on demand - I sort of let them work out their own scheme really. I find with her she sort of still alters, she goes some days every four, some days every three, some days every five - and I just feed her whenever she seems to be hungry.

Carol: Yeh, so that works for you, eh. You're at home eh?

Mother: Oh, yes (laughs).

Carol: With four kids you must be. And, um, looking a bit ahead to the future. When do you for instance add cereals or solids?

Mother: I usually...like to wait until they are at least three months, preferably until nearer six months.

Carol: That's great.

With Mrs. Harris it was important to assess when she normally started cereals, as guidelines had changed since her last child. At that time early introduction of cereals was advocated. Now they were not being recommended until four to six months. Carol discovered that Mrs. Harris did not intend to introduce cereals early and so there was no further need for discussion. The mother watched closely and remarked "That thumb sure tastes good, eh Rachel?" and when the baby whimpered "Just terrible isn't it babes?"

Carol examined the baby and remarked on her runny nose. Mrs. Harris explained that all her children had had colds but that Rachel did not appear to be feverish. She had been using a humidifier in her room. Carol reinforced her action, "That's all I'd advise at this time."

A little later in the examination she noted the baby's fair skin and asked how the other children were in the sun. The mother responded, "I usually have them all with little suntops on them." Again, this illustrates Carol's anticipation of future problems, and her desire to prevent their occurrence. When she reached the part of the interview where she inquires about family relations Carol said:

Normally I'd ask how your sanity is - but you seem quite cheerful.

Mother: (Laughs).

Carol: Is it sometimes hard?

Mother: Occasionally, but that's when you say, "Get to your bed everyone, it's time for a sleep" (laughs).

Carol: Did you plan to have them that close together? (All the children are pre-school).

Mother: I said I wanted six.

Carol: Are you going to have any more or is this the last?

Mother: I'm thinking of it - yes.

Carol: Boy! You're obviously coping - quite well!

Mother: Yes, I enjoy them.

Carol asked about sibling rivalry in such a large family and Mrs. Harris said "They all show a little bit of jealousy. You can tell by the way they react with each other, but my husband really is good at playing with children. They enjoy seeing their Daddy get home."

Mrs. Harris said she had been a nurse but had no desire to go back to work. "It would be more a case if something happened to my husband, I'd choose that as a job rather than anything else." Carol was overwhelmed at the thought of four children but Mrs. Harris pointed out that when her parents were children families were large and there were no conveniences like washing machines, "I think if they could do it, can't I?"

Carol explained that the immunization schedule had changed recently and so would not be the same as it had been for Christine, who was now a year old. In keeping with agency policy she went over the consent form for immunization, but said that with the new policy Rachel would not have her first immunization until she was two months old. "You can book today if you want, but you may not know when you want, so just phone ahead."

Evaluating Family Function

In identifying the priorities in the visit Carol explained that with a new baby she was very interested in the history of the pregnancy and in completing a physical assessment on the baby. "I think the first visit is the most important visit and it's important to get as much information as you can. A good baseline for the nurses in subsequent visits." She felt that Mrs Harris was coping well. "It's obvious to me she's loving being a mother, and being with her children, and contemplating two more, I have no worries about her." She also thought that, "father is very much involved and is helping her when she needs it." She also noted that Mrs. Harris was "very competent at diapering the baby, at ease handling her - it's obvious she has lots of experience." Carol also noted that "she was verbalizing well - I said 'four children under four' and she said, "Yes, I like it.'" She added, "I can't remember the exact words, but you'll have them in your notes." Carol also saw Mrs. Harris as realistic, "she knows there's times when things go nuts" but she has a plan to cope with this "when she's tired it's rest time for everybody." "I observed her to be coping quite well but she verbalized it too."

Carol was astonished by Mrs. Harris's ability to cope with her large family:

> It really amazes me personally. She could say she was quite happy doing this [looking after four pre-school children]. She hasn't

> contemplated going back to work, so obviously she's quite happy - mothering is important to her now. (4/10/79)

In this evaluation Carol sees strengths she believes to be important. The mother's ability to verbalize; her satisfaction with her life; her ability to order her daily activities and those of her family, her love for her children. She also sees the mother as having a strong support system in the husband. Mother is knowledgeable about care and it is obvious to Carol that she is coping well.

The Structure of the Visit

In contrast to her district, Carol did not see any mothers who had problems while I observed her in clinic. Her actions with Mrs. Rolands and Mrs. Harris were representative of her interactions with other clients in the clinic setting. I asked her if she found she interacted any differently with clients in clinic, as contrasted with clients in other settings. She thought about the question before responding.

> I don't know if I could give you examples how I am different but I think I must be. It boils down to solicited and unsolicited advice or interaction. When clients come to clinic they solicit care.... A lot of the time when you're in the home it's unsolicited, at least initially. So you have a lot of convincing - that isn't quite the word, but you certainly have to back up why you are there, what you hope to do, all that kind of stuff before you get into the meat of the matter. At home you have to persuade them into accepting you. Clinic is more structured, I have a new baby format that initially I try and follow to make sure they [clients] understand why they are here and what they are going to be told. It's more unstructured in the home - at least initially, until you find out where you are.

Group Teaching

Within the clinic setting group teaching formed a part of the nurse's workload. While I was observing Carol she did not take part in any prenatal classes as she was supervising students from the University who were practice teaching. "I enjoy doing it." Carol frequently had calls from the students checking out details of the classes. At coffee she said to the other nurses, "Those B.Sc. students [nursing] are doing a great job - they really have the parents interested."

When speaking of prenatal classes Carol indicated that she believes they serve both an illness prevention and health promotion function.

> Having a baby is a predictable crisis and if nobody intervened the parents might be just fine, or there might be sickness resulting. Sickness is...maybe the mother can't cope with the baby or whatever...I am using prevention when I provide them with some tools to work with or to prevent a crisis. In general I am promoting a lifestyle that goes beyond the prenatal period or even the post partum period.

Carol suggests that the nurse teaches prenatal nutrition but that if the parents grasp the ideas one is in fact teaching nutrition for life. "This is the promotion part, that I want you to be conscious of good nutrition." She also says while she teaches prenatal exercises she tries to point out the advantage of exercise in general. "This is one area where I really do feel I get a chance to talk of health promotion."

I did see Carol with a group of student nurses in a hospital diploma programme. When the students came out to the unit for a half-day much of the time seemed to be spent in explaining the services. Carol had been instrumental in suggesting the nurses go to the hospital and meet with the students to give them an orientation: she had teamed with Ruth to develop this orientation. Carol spoke of the philosophy of community health nursing. She told the students that community health was "getting at problems before they became a crisis or talking to people before there is a problem." She said, "I see as a goal making people happier and improving their quality of life." She added "public health nurses don't have a solid philosophy." She again reiterates her belief: "It is important to give them [clients] the facts, also to strive to help people help themselves." (1/10/79)

Carol sees herself as a good teacher. She had the interest of the students in the group, who listened apparently attentively during her talk. She was both logical and concise in her presentation and her enthusiasm for her job seemed to me to come across to the group. Her perspective as she talked to her class was consistent with the ideas she expressed during her first interview, but there were only a few days between the two events. In her final interview she did express similar views on the role of the nurse in promotion and prevention in the community. (22/2/80)

When Carol moved to Redfield clinic she became involved in a senior citizens' group. This involved a group of ladies in a senior citizens' lodge who took part in a fitness and exercise class each Wednesday morning. All these ladies were of German or Polish background, one or two did not speak English, but they still joined in all the activities.

As each lady arrived Carol greeted her by name and asked her to wear a name tag. She used their names when speaking to them and personalized her comments. In the exercises for example she said:

"Well Olga, you can really get your knees up."

"If you're getting tired Bertha, take a rest, don't do more than you feel like."

Carol knew one of the ladies, who did not speak English, had been sick, and she used Bertha to check that she had been to the doctor and what he had said to her. Carol also checked a blood pressure, remarking "It's down from last week, it's only 140/90 which is good. You're taking your pills regularly now?" The lady said she was and Carol checked the number and times against the dosage on the bottle.

Bertha was angry because the manager had suggested having some dancer in to perform. The only room that could be used was the room that doubled as a chapel. Chapel was obviously important to these ladies and Bertha said "We don't want dancers in here, it's our place of worship." Carol supported her: "It's your home Bertha and if you feel strongly about the dancers you should say so. You have the responsibility to let people know the things that make you happy or unhappy in your home." The ladies obviously enjoyed their exercises and the short health talk. When Carol said Lorna, the nurse who had been previously, would be back the next week, they were anxious to be assured that Carol herself would be returning in the future.

Carol reinforced these ladies' efforts and their right to make decisions about their life. She also treated them with respect, making an effort to use their names. With the lady with hypertension she checked her understanding of the treatment that had been ordered for her, which supports her perspective that clients should take responsibility for making decisions about their own health. (23/2/80)

Summary

In clinic Carol saw herself as having a different priority than in the district setting. Clients came to her with a predetermined purpose, looking for counselling and guidance. While she still developed a biography of the client on which she based her assessment of the level of individual or family function, she did not focus her effort on developing decision making behaviour in the client. Her focus was, by her definition, on health behaviour. She assessed the potential for problems and provided anticipatory guidance.

In clinic conflict between Carol's beliefs and the reality of the situation were minimal. Agency guidelines were seen as flexible and advice tempered to meet the needs of the client.

In group situations while Carol was evidently the leader she showed her respect for client's feelings and ideas. She saw prenatal classes as a vehicle for both preventive and promotive intervention. While both clinic visits and the teaching situations were highly structured, Carol remained warm and friendly in her interaction with clients.

Carol's Perspective of Nursing

A perspective consists of three dimensions, the individual's definition of the situation, the action or activities the individual engages in as a result of that definition and the criteria of judgement used by the individual (Becker, Geer and Hughes, 1968, Cf. Chapter 3).

While these three dimensions are interrelated, for ease of presentation they will be presented separately.

Definition of the Situation

Carol believed that the major purpose of public health was to promote health by encouraging a healthy lifestyle. She ackowledged the fact that much of her work was preventive in nature, for example prenatal nutrition classes were designed to encourage sound eating patterns in order to prevent complications such as anemia and failure of fetal growth, however, sound nutritional patterns established in pregnancy could be carried on to develop a healthy lifestyle. Carol believed that her goal as a public health nurse was to help clients recognize their own health problems, identify possible solutions and then make decisions on what solutions would be best for them as an individual. She believed the ability to be articulate about health problems would transfer into other areas of the client's lifestyle and she saw as an ultimate goal the client's independence from the helping professions. Carol's model of nursing can be compared to Mayeroff's (1971) conceptualization of a helping relationship in which the goal of the helper is self actualization of the other. Carol believed respect between the nurse and the client was essential for nursing intervention to be effective. She believed that making a decision was more important than the type of decision that the individual made and that individuals who could articulate their problems were already making some progress toward independence. Her beliefs about nursing had roots in her own personal lifestyle, where she viewed decision making as important, and she saw these beliefs as reinforced by agency values, as articulated in the values, attitudes and practice training sessions she attended. Carol saw clients attending clinic as initiators of the interaction, in contrast to visits at school or in the home where frequently it was the nurse who made the primary approach. She felt that clients in clinic were already identifying a concern and came to the nurse soliciting care or advice. Carol viewed herself as enjoying her work whether it was with individuals or in a group setting

Carol's Nursing Activities

In Carol's interactions with her clients in the home or in school her application of her beliefs in her actions was evident. She did help clients to identify their priorities for care, but her efforts with children were not always supported by situations in which adult priorities took precedence. Carol showed respect for the individual's culture and its effect on lifestyle but experienced frustation with clients who did not wish to change their lifestyle, when she felt they were unhappy and that the situation could be improved. In her nursing she demonstrated a caring relationship with her clients, accepting their decisions and building on the strengths they possessed. While Carol experienced frustration with clients who did not share her values she was able to identify some of the pressures clients were under when they were visited by workers from many social agencies and she accepted their rejection of her intervention and their right to refuse the nurse admission to their home. Carol saw the lack of co-operation amongst social services as an impediment to client care and this was another source of frustration for her. Carol also interpreted the role of the community health nurse to clients, to teachers in school and to student nurses, she felt the role to be ill-defined and not even clearly shared amongst nurses themselves. Carol found working with some of her clients both exhausting and emotionally draining, but she had developed mechanisms for coping with the stress. These mechanisms included utilizing colleagues as a support system and retiring to the office to catch up on her paperwork when she felt she needed a break.

Paperwork was a conflict situation as it interfered with her priority of health promotion in the schools. In her district immunization had to be the priority at the beginning of the school year because of the transient nature of the school population. When Carol moved to Redfield Clinic she found the priorities changed. In the clinic Carol saw her role somewhat differently, her focus was no longer on decision making but on health behaviour related to the prevention of family stress. Her actions were therefore related to providing the mother with anticipatory guidance and information. With clients her actions included the collection of information, clarification of data, reflection on her findings, sharing information with clients and helping them identify preferred solutions. Sometimes client progress was slow but Carol did not look for overnight success, given the clients with whom she was working, she felt satisfied with any evidence of progress. In group situations Carol showed her respect for clients ideas and feelings while remaining the leader of the group.

Criteria of Judgement

In nurse-client visits Carol's major criteria for evaluating the client's capabilities was the responsibility they took for their own actions. She was concerned with the responsibility the mother showed toward the child and used the criteria of whether or not the mother brought the child for immunization as one indicator of this. Carol, in keeping with her own philosophy of a caring relationship, looked for evidence that the mother cared for the child. Here her concern was more with emotional care, as evidenced by bonding behaviour, than with overall cleanliness, but she did also seek evidence of physical care. With adults she looked for understanding of the others' point of view.

Carol also utilized practical experience and theoretical knowledge to make judgements about various situations. She was careful to note when she was making assumptions, as she did about the similarity of one child to other emotionally disturbed children she had cared for in the past.

Carol considered strengths and weaknesses of the family when making decisions about children. While she believed that whenever feasible parents should care for their children she arranged for a child to have his infected hand cared for in the school when she judged the mother as unable to manage. She also considered the culture of the family when assessing their competence and the way in which they were likely to approach care of their children.

Carol identified many of her clients as being reticent to use established health services, and saw them as having a low priority over matters concerning their childrens' health. When she moved to Redfield she contrasted parental concerns in the schools that she was responsible for in the two districts. The evidence she presented confirmed her conclusions about clients in the Greenfield area.

In the clinic Carol looked at the mother-child interaction, the general cleanliness (as opposed to neatness) of the children and the mothers' ability to verbalize their feelings as evidence of problems or lack of problems in a family. She felt clients who expressed satisfaction with their lives, who stated they were able to cope with their daily activities and who said they related well to their families were generally well adjusted. The children whom she saw in the schools who were maladjusted generally were unhappy in school and did not have sound communication with their families or sometimes with their teachers. The maladjusted mothers who were showing stress in their situations were also dissatisfied with their lives and often inarticulate about their problems. Therefore the criteria Carol used were reinforced by the circumstances.

Carol's model of nursing had five major elements: (1) a belief in a healthy lifestyle as an ultimate goal for clients; (2) the need to help clients identify problems and make decisions to achieve a healthy lifestyle; (3) a belief that there must be mutual respect between nurse and client for goals to be achieved; (4) a belief that the nurses role is one of an informed facilitator who guides the client toward a healthy lifestyle; and (5) a belief that the client is capable of becoming healthier and so independent of professional services. Her nursing activities and the criteria she employs to judge the situation are related to these elements. Her own convictions are strong and there are times when they inhibited her ability to accept a client's lack of motivation to change their lifestyle. She also was impatient with other health professionals who did not share her convictions.

CHAPTER 6

RUTH

Introduction

Ruth is in her late twenties, married with a young son. She graduated from a basic baccalaureate programme and has worked as a public health nurse for most of the five year period since her graduation. She was married before she finished her degree and, "my husband was offered a job in a community up North...so we decided to go". For Ruth, "one of the plusses...was that there was an opening in public health." If she had stayed in the city where she was living, "I wouldn't have been able to get in in the local area probably for a number of years until experience was built up." Ruth had intended to go into community health, "when the time was right" as she, "felt a pull in that direction". Her reasons for wanting to nurse in the community were, "the idea of prevention...I felt fairly strongly about that" and also, "the different atmosphere of being able to do things on your own". For Ruth community health nursing did not provide "the same constraints" as she found in the hospital setting. Ruth sees her original selection of the community for practising nursing to be based on professional rather than personal reasons, but it would seem both elements influenced her decision.

Personal Characteristics

Ruth sees public health nursing as supporting "my own feelings of independence and responsibility." She describes herself as being "practical" and adds, "I like to think I am organized, but at times I'm not so sure about that." In her work she, "enjoys the interaction of working with people." She also feels she, "cares about people". In appearance Ruth is slightly built, she dresses neatly and gives the impression of being orderly by her appearance. In contrast to Carol, who is outgoing, Ruth is quiet, but readily responds to others when she is questioned or if she feels she has a contribution to make. She enjoys nursing "But I wouldn't mind working part-time". Early in the study her son, Christopher, was ill and she had to take a few days off as he could not go to day care. When she returned Ruth said, "It would be nice to be home with Christopher; I realize when I have had a few days with him what I am missing." She also says, "When I get home, I am so busy with my husband and son that I don't have time to think of work." Ruth sees herself as being independent and likes to be responsible for her own decisions. She views herself as practical and organized, enjoys nursing but has family commitments that are also time-consuming. While she has a commitment to nursing, if there was an opportunity for a part-time position she would consider applying.

Public Health Nursing

For Ruth "the number one priority [in public health nursing] is education. Whether it's on an individual basis or in a group situation." Her rationale for this is that "in order to prevent something you have to provide people with a knowledge of how to prevent it." So for her education "forms the basis and the main priority" in her work. As a consequence she believes that:

> I have become involved in a lot...more formal teaching situations than some of the others nurses...as well as individual areas that are sort of automatics, the baby visits where you're automatically into a teaching situation to a certain extent.

She believes that by undertaking group teaching you "get the information to as many people as possible." Ruth feels that she uses "her knowledge and background of nursing [education] along with skills and information acquired in the job." She sees herself as, "at ease with people" and that this in turn makes the client "at ease when I am interviewing them or fulfilling the different parts of the job." As "people don't get all upset" when she interviews them she feels "personality and the way I approach people" are assets to her in her work. (28/9/79)

Ruth also sees as an asset and one "which maybe isn't directly service related" her ability "to put things down on paper say in a proposal or something like that." She sees herself as adept at "editing those kinds of things in a concise, direct to the point" manner. She feels this to be valuable in terms of her committee work. Carol also commented on Ruth's ability and said: "We can use that sort of help when we want to write a proposal for change."

For Ruth it is frustrating "working with families where you can't see progress happening." She says:

> I think, why me, why this situation? It seems like you're trying to work change within this family and...it seems like nothing is happening.

Ruth also gets frustrated by the amount of paper work that is involved in the job.

> It doesn't need somebody with nursing background to do it....You find yourself sitting there doing all this stuff, thinking "anybody on the street could do this, why am I sitting here when I could be doing something else that is nursing." (laughs)

Satisfaction in the job results from seeing "families on the other end where you feel you have been able to help them come to some selections or changes." She finds "short term types of things" such as, "concerns with new infants" satisfying but also enjoys teaching, "with the kids in shool...I enjoy doing that and feel good [about it]." In relation to education Ruth feels "there often doesn't seem to be enough time to do enough of the education kind of thing...that probably relates to the paper work thing." She thinks about doing what she considers to be "non-nursing things" and feels that education "becomes the option, you do it when you can fit it in - and that's frustrating for me." Other nurses feel the same way as Ruth. At a meeting at Redfield Clinic which I attended with Carol (26/2/80) one of the nurses said, "I'd like to do more teaching, but with the agency, immunization and screening are the priorities - any teaching you do is optional after you've done that." Another nurse added "I did some teaching early on this year, I thought it would help the kids get to know me. Now I'm all behind with agency priorities - never again!" There is some conflict here between Ruth's perception of herself as an independent practitioner able to set her own priorities and perceived agency priorities.

Ruth believes that: "the basic philosophy I come from is strongly prevention" she feels "if we can provide education for people" which will give them "knowledge from which they can make choices about their lifestyle and what they want to do with it" then "we're doing public health by providing public education." (28/9/79)

For Ruth "prevention" is more crisis oriented than "promotion". She believes promotion to be "starting from where people are at right now and trying to build on that to improve their level of health or lifestyle." (18/2/80) Prevention is "more oriented to a particular problem or something that's happening" or that "has happened in the past," in the latter case "we look at preventing that from happening again." In the case of immunization the goal is "prevention of the diseases before the kids will get them." Vision screening is prevention because "it's a case of trying to pick up problems rather than promoting anything." However, "I think the discussions you get into while you are doing screening provides a vehicle for [moving toward] a promotion angle." (18/2/80)

Ruth feels the terms "patient" and "client" are interchangeable in her conversation. "I think 'patient' probably is a throwback to hospital terminology as opposed to 'client' which tends to get used more in public health." She added, "patient tends to refer to somebody that's sick in hospital...but for me it's one and the same." (18/2/80)

Ruth believes that mutual respect between the nurse and client is essential in nursing. "If the client doesn't respect me and what I stand for...then I don't feel I can do much for that family in terms of trying to help them...." In return Ruth feels that she must "respect some of their rights and respect them as different from the last person I saw". If there is not mutual respect, "I don't think I will get very far because they will be able to feel that during our interaction." (22/11/79)

In looking at herself Ruth feels that if the frustration level gets too high it will affect her work with clients.

> If I'm feeling particularly frustrated and sort of upside down myself, perhaps feeling somewhat confused about what I'm doing or what I should be doing...it's bound to come out in the work or how well I deal with various situations. [If I'm frustrated] it's difficult to drum up the enthusiasm to go out and attack a problem situation....I'm not saying that it sort of totally takes over or I become non-functional or whatever...but I'm sure there's still some sort of side interference.

I asked Ruth what different activities she saw herself as involved in when she spoke of client education.

> Everything we do is a form of client education whether its counselling in the afternoon clinic setting or interacting with kids at school or home visits with moms. I think it falls into the majority of activities we are involved in whether in individual or group settings. (18/2/80)

She believes you ascertain the client's need by "questioning... questions they bring me and then questioning them to determine what they have tried in a particular situation, what they know about a particular problem." Her action then is "to correct some of the information if it isn't accurate" or to, "add to the information they already have." Ruth firmly believes, "if we don't increase the knowledge of people that are coming to us, then I really don't see how we can ever attack anything on prevention."

Summary

Through the process of self indication Ruth defines her perspective of nursing. This perspective is centered on her belief that to prevent something the client must have knowledge both about the health risk and the method of prevention. She sees education as a key function of the community health nurse both in individual and group situations. Questioning and observation are important ways of gathering information in order to determine the basis for teaching. She sees herself as a knowledgeable source of professional and practical knowledge which can be used to provide the client with information. In order to understand how Ruth's perspective guides her actions it is necessary to examine the context within which her nursing takes place.

Common Events in a Working Week

When I asked Ruth to describe her working week she said, "Probably I have two typical days in a week, one in which I go to school first thing, the other where it's not school initially." Ruth usually comes into the clinic first thing and picks up whatever she needs for the morning. On arrival at the school she has "a brief interview with the principal" to see "if there's anything happening I should be aware of." Then Ruth checks her mail box to see if she has any referrals.

> The schools I have are not particularly problem schools, in that there's not a lot of referrals from the teachers for things like cleanliness...mine tend to be more of the programme oriented types of things, visual screening...and also some of the educational things...in the classroom or as a resource to the teacher in getting materials.

School work takes until lunchtime, the afternoon being spent in the clinic or in home visiting. Ruth sees her area as being relatively low in terms of the numbers of home visits she makes when she compares it with other nurses in the clinic. In her own area she perceives the families to be "mainly middle-classish" without "a lot of problems", but she has one area where the population is more transient. In clinic "[you get] quite a cross-section of the population...from new babies through pre-school to the adult population, but typically it's more children." Ruth did not mention meetings as a part of her working week, yet in observing her at work it appeared they took up a considerable amount of time. Her actual involvement with clients was limited to approximately three and a half days out of the five day working week during the two weeks I recorded her activities (Table 6.1).

This limited client contact was not Ruth's choice but was related to the city wide inservice held in November each Thursday morning and to her attendance at the values, attitudes, and practice (VAP) workshops, which all nurses also had to attend, in February. Because of these activities observations had to be spread over two weeks to obtain sufficient information on nurse-client activities.

The time designated as spent on records in clinic was in part related to obtaining school records, but also included communicable disease reports and preparation for Early Bird Pre-Natal classes. Ruth also used this time to check the book, kept in the nurses' room, which contains new information, articles, or directives related to agency policies and programmes.

Ruth's District

Ruth described her district as "middle class" with "one pocket that is more low-income, more transient". In the middle class area she felt there were "relatively few problems", but in the transient area, "my visits tend to be much more basic regarding the starting point of my

Table 6.1

Activities in Ruth's Work Week Recorded by the Observer for the Periods 19-23 November, 1979 and 4-8 February, 1980

19 - 23 November, 1979

Days of the Week	Hours of the Day									
	8:30	9	10	11	12	1	2	3	4:30	Evening
Monday	Coffee, Clinic, Home Visit				Lunch		Clinic (Greenfield)			
Tuesday	District meeting				Lunch		Clinic (Greenfield)			
Wednesday	Coffee School Inservice				Lunch		School/Staff Inservice			
Thursday	City Inservice				Lunch		School/Head Combing			
Friday	Educational Meeting /Out of Clinic				Lunch		Educational Meeting			

4 - 8 February, 1980

Days of the Week	Hours of the Day									
	8:30	9	10	11	12	1	2	3	4:30	Evening
Monday	Coffee	Records		Home Visits	Lunch		Clinic (Greenfield)			Staff Nurse Assoc.
Tuesday	District Meeting				Lunch		Home Visits			
Wednesday	City Prenatal Classes Planning Committee				Lunch		Clinic (Richmond)			Early Bird Pre-Natal Class
Thursday	Coffee	School: Records Follow-up			Lunch		V.A.P.*			
Friday	V.A.P.*				Lunch		V.A.P.			

* City Inservice, Values, Attitudes and Practice.

discussion". She sees these families as having "more problem situations [when they have a new baby]". She also feels, "I'll be seeing those families more than once compared to the middle class."

Ruth's area did appear to be more homogeneous than Carol's. The houses were generally square, stucco buildings, in good repair with neat yards. When one went inside, the walls were papered and the floors carpeted. Windows were curtained to match the decor and the houses were adequately furnished. Even in the transient area the houses were of the stone bungalow variety, but they tended to look neglected with peeling paint on window frames and eavestroughs.

When Ruth spoke of agency priorities she said that she felt that in terms of home visiting her priorities and the agency priorities concurred. "I think my priorities agree with those the health department sets up...single mums, young mums, mums with first babies...I think those are my priorities." Generally she sees all home visits as equally important. "T.B. visits, the communicable disease things - I think I'd set them all about even if I had a stack of things to be done." There was one area that was, "considered an optional kind of thing and one you do if you have time" and that was bereavement visits.

> I have been fairly involved in that because of the type of area I have. I probably have more bereavement visits coming through in proportion to my baby visits...so I'm involved in more of these and I think it's a high priority...for the district that I cover because of the population.

However, Ruth felt that despite this need "my first priority is with younger children" because "the younger you can get to them the more information they will have to make choices sooner."

I asked Ruth if she consciously thought about agency policies when she worked with clients. She responded:

> On a baby visit you think in terms of what the policies are that the agency recommends for feeding or treatment of diaper rash or whatever. There are certain things that are recommended by the agency as standard policy in visits to do with communicable disease....It's not something that's sort of extremely conscious within my mind on every visit I go on...that's something that probably changes the longer you've been working at it. It becomes ingrained in what you're doing.... (22/4/79)

Ruth felt she had encountered little difficulty with agency policies except for one which stated that the nurse cannot tell the clients about their blood pressure reading after checking it. She sees this as a conflict with her own values because she believes "it's the clients right to know what is happening with their body", so she has "trouble justifying that as a policy, so in that sense I find it interferes with what I would like to do in that situation."

Home Visits

Ruth did seem to have fewer baby visits than either Carol or Kate, as a consequence she spent more time in clinic. The first visit she took me on was to a nineteen year old mother with a first baby who lived in the semi-industrial, more transient area of Ruth's district. Mrs. Curtis had telephoned the clinic the previous day and Lois, who had talked to her, had suggested to Ruth that a priority visit was needed. Despite a severe cold Ruth decided she must follow-up on the referral. The client's house stood by itself between a small business and a workshop. A large (and noisy) dog was tied to the back porch and barked at us on arrival. Ruth had contacted Mrs. Curtis, who was expecting us. She opened the door immediately in response to our knock. Ruth identified herself "I'm Ruth Friend, the public health nurse - I phoned to tell you we were coming, and this is Peggy Anne Field, the nurse-researcher, who will tell you more about her study." (19/11/79) This was Ruth's normal introduction of herself to the client.

Obtaining a Client Profile

Mrs. Curtis said, "Do come in. I've just fed her and she's in the sitting room. Take off your coat, there'a a hook behind the door." We took off our coats, hung them up and sat down. I got permission to tape the session. Mrs. Curtis was obviously pleased to have someone to talk with and when Ruth remarked that she did not know there were any houses in this area she readily explained how she came to live there. It appears that her father had bought the land adjacent to his shop. The house had become vacant and he had offered it to his daughter.

Mrs. Curtis:	We're still fixing it up because the house is over 50 years old and there's a big family that used to live in her eh? They really made a mess of this place I'm telling you.
Ruth:	Lived in, eh?
Mrs. Curtis:	Yeah, so we're just fixing it up right now. It's our home you know. I like it. It's small. Never lived in a house before, like on our own, so I thought it was time we tried it out and see how we like it.
Ruth:	You find it different than an apartment?
Mrs. Curtis:	Yes, that's for darn sure (laughs)! More bills to pay - higher bills.

In retrospect Ruth felt this might have been an indication that finances were somewhat shaky, but she did not pursue it further, switching the topic to her main purpose for the visit, the progress of the baby. Mrs. Curtis immediately launched into a long explanation.

Mrs. Curtis: Well the first week she was home she woke up for her 1 o'clock and her 5 o'clock feedings right on the button kind of thing...and the second week, it started one Saturday night, she didn't want to go to sleep, and unfortunately we were out at a party and my sister was babysitting. She's...well she's been babysitting babies for a long time...and, er she phones me up and says, "I don't know what it is but Karen wants to keep on eating she just doesn't want to go to sleep, like, I've had to sit with her for hours." So I said, "Gee" and we came home early and she was up all night and this carried on for five days. My eyes were just puffed out to here and I phoned the Well Baby Clinic and I say, "I don't know what it is but I think my baby has a touch of colic because she will not go to sleep at night."

Ruth: U-huh.

Mrs. Curtis: I told her "she's drinking up to four ounces - no problem at all...do you think I should start feeding her Pablum?" And she says, "Well, it could be that she's not getting enough to eat - that there's nothing that's filling her tummy" - so lately we've been giving her Pablum - mixed in with her formula/

Ruth: U-huh/

Mrs. Curtis: and she's been drinking that and she seems to be just fine, but she's really cranky. She's pretty hard to handle.

Ruth: Does she tend to be cranky now...at particular times of the day/

Mrs. Curtis: Yeah, Right/

Ruth: you know, one day is it in the morning, the next day does it tend to be in the afternoon/

Mrs. Curtis: Well/

Ruth: or does it tend to be fairly consistent?

Mrs. Curtis: Yeah, it's been right around between 7 o'clock and 12.

Ruth: Mmhh.

Mrs. Curtis: She wants to stay up and it takes a lot to put her to sleep...she just screams, sometimes she'll doze off and then she'll wake up... so, I don't know what it is (laughs)....

Ruth: Mmm.

Mrs. Curtis: She's having proper bowel movements - and we're giving her, like stewed apples, and it's warmed up and it's watered down so there's no problem - she enjoys it... and lately we've been giving her this medicine here...this colic water - gripe water...and it's been settling her stomach down quite a bit.

Ruth: U-huh.

Mrs. Curtis: Like she's not up all night long. Like this morning she woke up at three in the morning and again at nine - but at other times she'll be eating around ten then she'll stay up until twelve and then she'll go to sleep and sleep right through the night and won't usually get up until around seven or usually nine o'clock.

Ruth: Mmhh. Well, that's not too bad then.

Mrs. Curtis: It's not too bad yeh - but she's really super cranky before she goes to bed though and that's what I don't understand.

Ruth: Well, often with colic they do tend to be fussy in the evening and...you know, for two or three hours around their last feeding time or up to their last feeding time...and it certainly does sound as if she's tending to those symptoms.

Mrs. Curtis: Yeah.

Mrs. Curtis had a need to verbalise her concerns and Ruth showed herself to be an attentive listener. Earlier Ruth had indicated that as far as she was concerned clinic policies were not inviolate and that if a mother had a baby that appeared to be hungry solids would be suggested before four months of age. Ruth asked questions for clarification as she attempted to get a clear history of the baby's cranky behaviour. She believes in the importance of questioning to get to the basic educational needs of the mothers. She asked Mrs. Curtis if she had called the doctor and the response was that he was hard to get hold of and she can really manage, if only the baby wasn't so cranky every night.

Ruth: Yeah. It gets pretty difficult to handle when they constantly cry and it does not seem to matter what you do to improve the situation - you feel pretty helpless at those times...I think.

Mrs. Curtis: Well, you feel like, you know, I change her at the right time, I bathe her and everything, and a lot of things don't seem to work. Like my Mum says "Do you heat up the formula?" and I say "Oh, yeah, you know it's heated up and so is her food and all that", and I give her a warm bath because that kind of calms her down like, she's always got stomach cramps. Well, the gripe water's helping a bit, but at night it doesn't. I give it to her right before the feeding, the gripe water - and then she drinks and then I burp her - and then she has more formula.

Ruth acknowledged Mrs. Curtis' feelings and she responded by saying she is trying hard to do everything right, so why is the baby cranky? Ruth clarified some of the information Mrs. Curtis had provided and then went on to discuss other steps she might take in tackling the problem.

Providing Alternative Actions

Ruth: You're using it for every feeding then? [the gripe water]

Mrs. Curtis: Well, you're only supposed to use it four times a day.

Ruth: U-huh.

Mrs. Curtis: Because it's got alcohol in it.

Ruth: Right.

Mrs. Curtis: But I give it to her right before she gets fed. Four times - nine o'clock in the morning, then at lunch then at night, then in the morning if she happens to wake up.

Ruth: I see. O.K. Um - one other thing you can check with your doctor if it does continue is sometimes they can provide medication to settle their stomach and ease the cramping for them - and it can make quite a difference - if it would continue up until that time, well certainly check into that, when you go [to the doctor]. I don't like to sort of, push medication on little babies, but sometimes it is necessary for a short period of time in order to stabilize the situation, and what's going on, and give them some relief as well as yourself.

Mrs. Curtis: Laughs. U-huh.

Ruth: If that will do the job then it may be in order to look at something like that.

Mrs. Curtis switched the conversation to other concerns that she had (when can juices be started and whether the baby can see or not). She was soon back to voicing her concern about the baby's colic and the fact that the baby will not settle to sleep, "when I laid her in the crib, she always wakes up." Ruth questioned her further: "Have you left her there? Like when you put her down for a few minutes as she starts to cry have you left her there to cry?" "No, I pick her up. I don't know if that's right but I do." Ruth explained to me later, "I don't think it's a question of right or wrong...". In talking about counselling she said: "With new Moms I think it's important not to make them feel guilty." She used the approach that things are not right or wrong, but that these are alternatives that can be tried. She proceeded to explain to Mrs. Curtis that new babies can form habits.

> There are times when you can leave her and see if she settles. I think during the colicky times it's going to be much more difficult to leave her and probably you're going to have to take some steps to relieve the cramps and make her comfortable....Other times of the day if she's been fed and burped, her diaper's dry, you know, and all those things have been checked and that's not a problem for her, then maybe she's just wanting to be held...and at those times you may be able to leave her and find out if she will drop off to sleep on her own.

Helping the Client Understand the Problem

Mrs. Curtis again described, at length, an episode that occurred the previous evening. Ruth asked, "Have you tried a pacifier?" and Mrs. Curtis responded, "She usually spits it out...I don't think she likes it at all." She then asked, "What can it be that upsets her so?" Ruth explained that basically it's a stomach spasm, that gas builds up over the day and that colic does seem to occur in the evening. Mrs. Curtis responded, "Yeah, it sounds like that's exactly what's happening." Ruth then said, "This is a handout we have on colic, what it really is, and I think your baby fits the description fairly well, crying times, fussy times, indigestion, passing gas, the type of behavior you've been talking about". Ruth pointed out the suggestions for management - then said, "Bicycling the legs, do you know what I mean by that?" Mrs. Curtis shook her head. "If you have the baby on their back and move their legs back and forth - similar to the motion of a bicycle". Mrs. Curtis commented that the baby seemed to do that when she had cramps. Ruth responded, "It may help if you assist them a bit". She went on to provide other practical suggestions on positioning both before and after feeding. Again she reassured Mrs. Curtis that the colic was not her fault, using the literature to reinforce her explanation.

Ruth: I think this other section is important to look at too - the idea that there is nothing you're doing that is drastically wrong - um...the big thing to point out here, you know, maintaining confidence in your own judgement - it's really common for parents to get the idea that they are doing wrong....

Mrs. Curtis: (Laughs). I feel that way all the time.

Ruth: You feel - inadequate might be the word, just not being able to figure out what to do to calm the situation down and this type of thing. I'll leave this with you to have a look at - and maybe your husband will appreciate having a read too -

Mrs. Curtis: It'll help quite a bit.

Ruth: It's a little easier if you understand what's going on.

Mrs. Curtis: Yeah.

Ruth: Something you can do.

Mrs. Curtis asked how soon colic settles down and Ruth responded, "With most babies it lasts around two months". Mrs. Curtis paused, then said, "Well - she's three weeks. O.K. - so I have only a month and a week left." She seemed more relaxed at this point than she had been throughout the visit.

Ruth: Laughs. Looking on the bright side eh?

Mrs. Curtis: It's not that bad. It's just that at nights she gets so cranky but now I'll try just leaving her - letting her cry for ten minutes and just go outside or something.

Ruth: Well, er - I think it's important that you put her in one place and you go and shut the door.

Mrs. Curtis: Or plug your ears!

Ruth: Yes, sometimes you have to - in fact I know a woman and she was going through the same kind of thing, and she went and sat on the front porch for a while until the baby managed to drop off to sleep.

Mrs. Curtis: Calms down.

Ruth: And, because it was very difficult for her to just sit there and let the baby cry.

Anticipatory Guidance

Here mother and nurse engage in a free-wheeling exchange. Ruth gave advice from her previous experience, speaking of another client, conveying the message "you are not alone". Mrs. Curtis told Ruth she got so edgy that she was quarreling with her husband, but she realized what was happening and now suggests he go outside if "the baby's bawling."

Ruth: It's important for the two of you, you know, to keep the talking open and really talk about the things that are bothering you.

Mrs. Curtis: Right.

Ruth: At the time that it happens.

Mrs. Curtis: Right.

Ruth: And not, you know do what a lot of people tend to do, and it's very easy to do, is put it off. It's a little thing now but it sort of sits there and another little thing happens.

Mrs. Curtis: Yeah, and it's hard.

Ruth: By the end of the week everything's piled up and then there's a big blow/

Mrs. Curtis: everything blows up/

Ruth: whereas if you deal with some of the small things as they're happening, then, um, you don't have that potential for build up/

Mrs. Curtis: that's right/

Ruth: because it's been dealt with/

Mrs. Curtis: That's right.

Ruth: So it's important for the two of you to talk over what's happening and the problems that you're having with the baby - um and things about the two of you and what you're going to do - you need to keep it in mind that the two of you as a couple still exist.

Mrs. Curtis: Yep/

Ruth: you're not just Mum and Dad now/

Mrs. Curtis: Right/

Ruth: finding some time for yourselves is important.

Clarification of Misconceptions

Ruth picked up on Mrs. Curtis' concern and led the conversation so the focus was on the need to plan for an evening out with her husband. She gathered information on the family support system asking: "Will your mother babysit if you want to go out?" With Mrs. Curtis' anxiety reduced Ruth was able to get a history of her labour and delivery, discuss birth control and immunization. It was evident that Mrs. Curtis had a stock of half-understood facts. Typical of this was an exchange related to crib death, and Ruth tried to correct the misinformation.

Mrs. Curtis: My mother told me to...um, when the baby's at home leave on a radio or something, because - a child like - we make lots of noises in here.

Ruth: Mm.

Mrs. Curtis: T.V. pretty well loud or the radio or banging pots and pans or whatever - that doesn't bother her. If a baby's used to silence, you know, usually crib-death follows because you're tiptoeing round the house and telling everybody Sh-sh. I know somebody who had a baby that died that way. She was always going (drops voice) "Sh-quiet please" kind of thing and everybody's trying to be so quiet and not bump anything on purpose and the baby ended up dying - after a month old because it was just too quiet.

Ruth: Yeh - I'm not sure you can relate the crib death to the silence, there are a lot of theories, as to what causes crib death, different viruses, something in the metabolism of the baby, the body not functioning, a variety of things.

Mrs. Curtis: Right.

Ruth: And I don't think it can really be related to the way the baby's been treated by the parents or what sort of discipline they had, or whether it was a noisy house or a quiet house. Those kinds of things I don't think have been related as a factor.

Mrs. Curtis: Mmhh.

Ruth: I think it's probably more coincidence that it happened in that case. But it's a very real concern for a lot of parents because it is the type of thing where there's not advance warning - in the majority of cases the baby has been perfectly normal and fine and it all happens very quickly.

Throughout this interview Ruth was alert to the mother's concerns and misconceptions and provided information to clarify current knowledge and anticipate future problems. She contacted Mrs. Curtis again the following week and reported that the baby seemed quieter now and that "the Mum seems much less anxious, she really didn't talk much on the phone."

Another visit Ruth made was to Francoise Messier and her two week old son Nathan. She said "I thought I'd call this afternoon as I have time. She has no phone so you just have to keep trying." Mrs. Messier was caretaker of a block of flats and also baby-sat a two year old girl on a regular basis. Mrs. Messier said, "She is almost like my own at this stage - and she responds to the baby by being jealous." Ruth had been concerned about Mrs. Messier, whom she had met at prenatal classes. "I was worried - she had moved here and was alone [she had] no family."

During the visit Mrs. Messier indicated she had no problems with Nathan who was feeding and sleeping well. Her husband was a cat operator and kept irregular hours but she indicated she had got to know a few people in the block. Ruth asked her if she knew "Mrs. Stevens - she has a fairly new baby and lives on the next floor." Mrs. Messier knew her as a tenant but not to speak to socially. Ruth suggested "Perhaps you could make some arrangement with her - you could look after her baby when she wants to go out and she could do the same for you." She did not reply to this but raised her own concerns. "When I first got him home I was so worried, I was afraid I'd not know what do do when he cried. But after the first few days it seems to be okay." (16/10/79) When Ruth looked back on the visit she said "After some initial anxiety she is doing surprisingly well."

This visit contrasted with the one to Mrs. Curtis. Mrs. Messier was relaxed with her son while Mrs. Curtis was still extremely anxious. Ruth spent about an hour and a half with Mrs. Curtis but the visit to Mrs. Messier took only twenty minutes. This is one of the difficulties the nurse has in the home setting - she never knows how long a visit is going to take. However, Ruth sees flexibility in her area, "because I have limited visits to make", so she can frequently priorize her time in the situation and "adjust my plans for the day as needed."

Identifying the Problem with the Client

The same afternoon we made a visit of a different nature. Simon Chu was a student at a local university affiliated college. He had recently arrived in Canada from Hong Kong and had been found to have intestinal parasites on screening. The laboratory had notified the clinic that they had not received his second stool specimen, so Ruth had to check on this to find out what had happened.

> Often it is a matter of their not understanding the instructions - sometimes their English is poor, sometimes they misunderstand the mailing instructions - sometimes they have moved and never got the notice.

When we arrived at the college we went to the secretary's office and from there we were directed to the Assistant Dean of Students. Ruth said, "I'm never sure how much to tell them to get co-operation without breaking confidentiality." We finally were told to go and knock on the classroom door and call Simon out of class. When he emerged Ruth explained who she was and the purpose of her visit.

Ruth: I am a public health nurse from Greenfield clinic, have you had a letter telling you to collect a specimen container from the clinic?

Simon: Yes, I got it last week.

Ruth: When did you mail it in?

Simon: Thursday, I think.

Ruth: You understand what it is all about?

Simon: Yes, I had worms. I asked the biology teacher and he said it was not dangerous. Is it?

Ruth: No, but people over here do not normally come in contact with this kind of worm, so they can spread rapidly. It is important you wash your hands thoroughly after you go to the bathroom. In your country they are common but here we must get rid of them because of the danger of infecting others. If this specimen is still positive you will have to see your doctor and have medicine. Do you have a doctor?

Simon indicated that he did not and Ruth said that she could help him find one if needed; that is if she heard that the stool was still positive.

Simon: If it is still positive I will have to see the doctor and have pills, is that all?

Ruth: Yes, the treatment gets rid of the eggs so cleans the worms out.

Simon: But if the stool is negative that is all?

Ruth: Yes, then nothing further will be done.

Ruth, in keeping with her belief that client's have a right to know what is happening, gives Simon a thorough explanation of the problem. She also cautions him on the importance of hygiene to protect others. In this case she said, "I like them to realize it's a common problem in Hong Kong, so they don't feel it's serious, but at the same time realize why it's of concern in Canada." She also anticipated that Simon, being new in Canada, might not have a doctor, and offered assistance in case it was needed.

Respect for the Client

Another visit was related to immunization. Ruth was following up an immunization record from Aviemore School. The child in question, John, was from a Korean family who did not speak much English. It had been difficult to determine what immunization he had had and contact over the telephone had not been satisfactory. Ruth had arranged to see Mr. Chin at home that morning. "He works in a restaurant, so he is home in the morning. I think his wife works too". She explained, "We think John has only been immunized for smallpox but I am having trouble confirming this."

The house was just a street over from the school. It was well built but in need of repair. When we knocked there was a delay before Mr. Chin answered the door. He was wearing slacks and an undershirt and his shirt was unbuttoned. It looked as if we might have got him out of bed. However, John was playing in the living room and he was dressed.

Ruth:	Is John sick that he's home today?
Mr. Chin:	No. He have hole in his - how do you say? (points to teeth).

Ruth: His teeth? Is he going to the dentist?

Mr. Chin: Ah, yes. Today he go. At twelve. I take.

Ruth proceeded to ask Mr. Chin about immunization. "Has he had his immunization - his shots for polio, measles, diphtheria?"

Mr. Chin: Ah. No. He have some shot.

Ruth: For diphtheria?

Mr. Chin: I think he have no diphtheria and the paralysis - you know when part of body not work.

Ruth: Poliomyelitis?

Mr. Chin: I don't think - what we call it - me get dictionary.

Ruth: Um, polio...paralysis.

Mr. Chin: Me get dictionary.

Ruth: That's good.

(Fetches dictionary and looks up Korean word)

Mr. Chin: Infantile paralysis.

Ruth: Oh yes. That is the same. Good. Now we can give John his shots if you want.

Mr. Chin: I do want. Soon. You give injection. We move soon - December four - South Side...

Ruth: If you move I send message to nurse at Redfield. She will give shots.

Mr. Chin: You do shots?

Ruth: I tell nurse at new school what John needs. You will not have to do more.

Mr. Chin: You see it done?

Ruth: Yes. It will be done. I have information now.

Ruth spoke to John who smiled at us both and we said goodbye to Mr. Chin, who was profuse in his thanks that we called. In the car Ruth was concerned, "I tried to keep what I said simple - I hope Mr. Chin did not think I was talking down to him." She said she found these visits difficult because "I am always afraid of underestimating their command of English, yet I am afraid if I don't simplify my sentences they won't understand, yet I would hate to insult anyone." Ruth showed her concern for the individual here and was sensitive to the danger of unintended insult to another person. She also tried to adapt her information to the perceived level of comprehension of the client. (10/11/79)

Resources for Educating the Client

When Ruth talked about client teaching she indicated that she used "personal knowledge and experience" in a particular area. "I also hand out tear sheets and pamphlets to give the person something to look at at home." This was evident in the visit with Mrs. Curtis when she utilized the agency handout on colic. When we visited Mrs. Holden, a mother with a two week old baby, she again made use of agency pamphlets to support her instruction. (5/2/80)

Mrs. Holden: When do I bring him to the clinic for shots?

Ruth took out the agency pamphlet describing the clinic and the work of the nurses. It also contained the immunization schedule. She sat down beside Mrs. Holden and using the pamphlet as a guide described the schedule. She added:

> You do have to sign a consent for immunization and this record goes with the child into school. When it is time for the immunization you must call and make an appointment. We use an appointment system because we find Mom's don't have to wait so long.

Ruth then obtained a history of Mrs. Holden's pregnancy, labour and post-partum progress.

"Did you have any difficulties in pregnancy?"
"Did the baby come when expected?"
"How was your delivery?"

Mrs. Holden said she had attended prenatal classes. Ruth explained she was particularly interested in prenatal classes. "How did you find them?"

Mrs. Holden: I went to the University Hospital classes and they were quite good. My husband didn't know if he wanted to go in for the delivery - now he tells everyone they should go!

Ruth: Were there any gaps? I mean between what was covered and what actually happened?

Mrs. Holden: They spend a lot of time telling you what you'll go through, this stage and that stage. I really didn't know what stage I was at. They gave me a shot!

Ruth: Did you see the delivery?

Mrs. Holden: No, I was out to lunch. I had a mask for oxygen. Then after they gave me the shot I was out. Whatever they gave me it sure works! The classes were good - I think they told you all they could, you'd have to experience it, it would be the same thing if you tried to explain it to someone else. It was different.

This conversation about classes related to Ruth's interest and is not a regular part of the post partum visit interview. Frequently nurses do not see their own clients post partum. I asked Ruth at one point how she assessed the effectiveness of her teaching on one-shot encounters, "I don't, but you can find out what clients have done with teaching given by other nurses and learn from that." This exchange showed the type of feedback she looked for in one situation.

Indirect Questioning

Instead of asking "Did the baby have complications?" Ruth asked the mother, "When the baby was born was she in the special unit for a while?" This directed the mother more specifically to the issue of complications. Mrs. Holden was well informed, "She was in there, she had fluid on her lungs. I knew a nurse on the unit and she said she was fine. She was back on the ward by 5 p.m." From the birth notice Ruth would know that the baby had had special care, this way of asking allows her to assess the mother's knowledge of events

Her next question, relating to weight gain, often an anxiety provoking topic for mothers, was a non-direct approach: "Do you notice her filling out?" Mrs. Holden responded, "Her legs are fatter". Then Ruth asked whether she had been weighed and Mrs. Holden replied, "No, she seemed to be growing". This non-direct approach appears to be typical of Ruth's handling of questions. She asked, "Does she have regular sleep patterns?" then when the mother responded, asked further questions as needed. Mrs. Holden said, "Yes - she sleeps through the night. It's close to seven hours now." Ruth responded, "That's great. With such a long sleep at night how frequently does she feed in the daytime?" As mother is breast feeding and the baby is only two weeks old the frequency of feeding is important in assessing adequate nutrition. Mrs. Holden's response reassured Ruth, "She goes three to three and a half hours and seems to be satisfied."

Providing Guidance

Mrs. Holden then raised a concern that she had relating to bathing:

Mrs. Holden:	I tried to bath her, she just hates it and screams.
Ruth:	Sometimes, at this age, they react to the temperature change and just being undressed.
Mrs. Holden:	When I get her undressed and just hold her out and get her feet in - she just screams.
Ruth:	How do you check the temperature?
Mrs. Holden:	With my elbow - so it is just warm.
Ruth:	Maybe you could warm it up a little bit more. If it's barely lukewarm it may not be quite warm enough.

Ruth again asked a probe question, making the assumption that the mother does utilize a way of checking the water in the tub.

Mrs. Holden:	I know when she gets her feet down she doesn't like it at all.
Ruth:	Maybe she feels insecure if you're holding her out. They're used to being held close. I think sometimes it's the fact that they're out there in the tub and not held close.
Mrs. Holden:	She does the same in the chair.
Ruth:	She may just be looking for contact. If she cries a lot just sponge her for a week or so, then try again, she may not mind so much. Try the warmer water first.

Ruth's advice here is based on both theory, her knowledge that babies feel insecure when not held close, and practical experience, the possibility that the bath water was too cold. Mrs. Holden asked about the baby's crying and Ruth explained the different types of cry and what to observe in trying to distinguish the baby's need.

Mrs. Holden:	Is it possible for them to be spoiled this soon? She's only two weeks old. This weekend we had all the family here, picking her up - now she screams when you put her down.

Ruth: I question the use of the word "spoiling". They can become accustomed to particular things. They get used to being held and they have no sense of time. If she had many people holding her she will be accustomed to it.

Mrs. Holden: I noticed a change while they were here. Today it's not so bad, but Monday it was terrible. Before she lay quietly. I didn't know they caught on that quickly.

Ruth: They can, but when the normal routine develops again you'll probably find she goes back. An upset routine takes 3 - 4 days to settle down.

Mrs. Holden: She does seem better today.

Ruth provided Mrs. Holden with information about the possible cause of the baby's behaviour change and gave her an indication of the time it would take to reverse. Mrs. Holden was able to acknowledge that she does see a change and appeared to be reassured. She moved on to enquire about the baby's vision and Ruth gave some anticipatory advice: "It is good to use a mobile - the best point is 12 to 18 inches above her face." Mrs. Holden responded, "The baby seems to see my face when I feed her" and Ruth asks, "Where do you hold her when you feed?" Mrs. Holden paused and then said, "Yeah, I guess she is about 12 inches away". This mother showed interest in her baby, she asked about jerky movements, cross-eyes, then remarked, "She's not going to be small long. She has a two month old cousin, strange how they grow so quickly."

Ruth asked Mrs. Holden how she was feeling, whether she planned to return to work and about birth control. In response to the latter question Mrs. Holden said, "I think I'll go back on the old reliable. I'd been on it four years and needed a break. But I don't want to get pregnant again - I can't cope with two." Ruth warned her about ovulation prior to menstruation, "When you resume intercourse you need to take precautions before you go back on the pill. Many women use the condom and foam at this point." Mrs. Holden responded, "Yeah, that's right. I hadn't thought of that."

Acknowledging the Client's Feelings

When Ruth asked if she had any more questions or concerns Mrs. Holden responded, "I can't think of anything. Not really, just I'm still adjusting to her I guess." Ruth acknowledged her feelings "Are you still feeling shaky about this?" "Not so much. Monday morning I felt all alone and shaky - but now it doesn't seem so bad."

Ruth:	What made you most anxious - wondering what would go wrong?
Mrs. Holden:	Just being alone, more than what would happen. Just the fact it was her and me.
Ruth:	Adjusting to the responsibility of having that little bundle that can't do anything for itself is a big step.
Mrs. Holden:	Yes being here with her - and even being here by myself is a big change.

Nurse and client discuss the change from having colleagues around at work to being alone in the house. Mrs. Holden said before she had the baby she thought it would be easy to go back to work but "now I think I can't give her to somebody else." Ruth wrote her name on a clinic card and said, "If you feel isolated as you did on Monday don't hesitate to call me. I may not be in, but there is always someone you can talk with if you call." Mrs. Holden got up and walked with us to the door. Ruth responded to Mrs. Holden's feeling of isolation and reinforced the availability of the public health nurses as a resource if she needed someone to talk with at any time. (5/2/80) This was compatible with her belief that if you provide the client with information potential crises can be prevented.

Assessment of Family Functioning

I asked Ruth what she felt to be important in this visit.

> Basically this Mom was very anxious but seemed to be over the worst of it. She was really concerned about the baby and what was happening - her questions showed that. The baby was obviously feeding okay - sleeping seven hours and the Mum had no concerns around that. I forgot to ask her [the baby's] name - and I don't think the Mom ever mentioned it. That might concern me at times, it could be a sign of rejection, but this Mum was even wondering about going back to work so I don't need to be concerned here.

Ruth synthesized a variety of observations to reach her conclusion that all is well. She added "I may telephone her in a few days, just to make sure she's settled down, but I think she's over the crisis now." I asked Ruth what the criteria were that she used to assess family functioning in a home visit.

> I think the practices that she is using at the time as far as feeding, caring for the baby, whether the things she's doing fit in with the types of things we encourage. Her level of calmness, or if she seems nervous. If I see her handling the baby...the way she is expressing herself may indicate that she is having some reluctance whether she is really able to do the job or do a good job. So the way she says things as well as what she says. (18/2/80)
>
> The support system is another thing I try to check out...whether somebody can come in and relieve them once in a while...be a backup for them. Sometimes you get a bit of indication about financial resources...certainly as to things available in order to look after the baby; sometimes you pick up things that might indicate educational level...at least whether they tend to read or not. Also, whether the house is a total wreck or whether it's neat may say something about mother's organizational skills and whether she can keep things under control. (18/2/80)

In her visits to Mrs. Curtis and Mrs. Holden Ruth gave evidence of collecting information in these areas and using them as a basis for her giving advice, giving information or providing guidance. In evaluating her visit to Mrs. Curtis she said:

> She was anxious and she had a lot of misinformation but she gave evidence that with support she could cope. She followed feeding advice from clinic and she did know she should restrict the use of gripe water. She worried about her ability to cope, about being young, but basically reassurance was what she needed. I think she'll be all right now, but I'll telephone her to check.

With Mrs. Holden she felt she was observant of her baby, knew how to use resources and that she would contact the clinic if need be. "She's got a normal level of anxiety but seems to have things well in hand." Ruth's judgement of the situation seems to be based on her perspective of what she identifies as important behaviour at the time of the post-partum visit.

Nurse-Client Conflict of Interest

When Ruth was asked to describe a situation with a client that she had found frustrating, she described a seventeen year old mother with a second child. Soon after Ruth started visiting her, as a continuation of the initial post partum visiting program, Jean had her two year old returned to her from the foster home where she had been placed toward the end of the her mother's pregnancy. When Ruth first visited her Jean was concerned about feeding probems.

> The baby was spitting up quite a bit, she would indicate she was keeping the baby on schedule every four hours, then say, in the same conversation, "Well, the baby will sometimes sleep five or six hours" and was giving mixed messages as to what was going on in the situation. (29/9/79)

The baby had also been born with deformed hands, "her thumb was there and the rest of her fingers are missing...they were shortened and looked more like a toe." Jean was having difficulty accepting the deformity. Ruth also felt she lacked family support and the putative father had disappeared early in the pregnancy. Ruth said:

> There are more concrete things like feeding, we made progress on... getting her to think what she was really doing with the baby, the problems with feeding...when the two year old came back she was not dealing with the usual acting out problems you encounter at that stage...she tends to do a lot of yelling at the child...not being very effective in disciplining...and that's a problem we haven't got far with at this point. (29/9/79)

Then the father returned, but Ruth felt that things were not going well. "One time she'll tell me 'it's going very well' and the next, 'we had a big fight and haven't been talking for two or three days'". Jean had opened up and was talking freely to Ruth but "I'm sure that we have not been able to work through a lot of the emotional things that have been going on over this period of time." Ruth believed mental health was integral to family care and in this case she felt she had only made progress with the basic physical needs involving feeding and caring for the new baby. She was also unable to convince Jean of the need for family planning "because she did not get pregnant for two years between the babies she believes she won't get pregnant for two years again." Ruth is dealing with a situation where her belief that providing information will help the client to change her lifestyle is shaken by the client's lack of motivation. "After all this time I think I've got across to her that she certainly can get pregnant...but she hasn't become motivated enough to take any action." When Ruth was telling me about Jean she indicated she had seen her every two weeks since the baby was a month old. Ruth ended on a positive note:

> The only sort of super positive thing is that the baby is now six months old and she made her first appearance at clinic two weeks ago to start immunization...which I really didn't expect would happen...

> it gives me a feeling we are really starting to get something going and can begin to work on some of the other things that have not been dealt with yet.

Ruth in assessing progress added, "I think she's increased the knowledge she had before but she has not gotten to the stage where she can actually do something with it." As Ruth sees satisfaction in her job coming from situations where she can start "part way down the road and sort of adding on to the knowledge base that person already has" one can understand her frustration in working with Jean. Ruth's beliefs about clients and desirable behaviour were in conflict with Jean's behaviour. Providing Jean with information did not result in a change in behaviour. Ruth showed perserverance however in her interaction with this client. Her stated priority for home visits was young and single mothers and Jean represents both categories.

A Conflict Situation

Ruth did not do any bereavement visits while I was with her. In part this was due to time constraints as bereavement visiting is optional and therefore a low priority within the agency programme. Another factor was that the supervisor, feeling that all the nurses were busy, had held back the bereavement notices. Ruth reacted to this by saying, "I'd like my notices. I may not give the visits priority but I'd like to make my own decisions." Ruth sees herself as independent and able to make her own decisions, this was one of the reasons she gave for working as a public health nurse. Here the supervisor was utilizing a parent-child approach to her staff (Berne, 1964) which conflicted with Ruth's view of herself as an independent practitioner.

Summary

In Ruth's district families tended to have adequate incomes to meet their basic needs. While the district included new immigrants the bulk of the population were Caucasian and had English as their first language. Ruth is an attentive listener and also obtained thorough histories on her clients, combining verbal information with her observations to form a profile of each client or family. She was alert to the need to clarify areas of possible misinformation. With new mothers she engaged in anticipatory guidance and counselling whether her role was intervening in a crisis or preventing one occurring. In teaching she utilized both verbal and printed materials to reinforce the ideas she was presenting. Her emphasis on the importance of providing clients with new information so they can function in an effective manner is evident throughout the home visits. Ruth was frustrated when a client was slow to make progress toward acting on her information but nonethelesss persevered with the intervention. Despite her early contention that bereavement visits were a substantial part of her home visiting this did not prove to be the case during the observation period. This can be related to two factors, first, there were time constraints due to in-service and meetings during time that would normally be assigned to home visiting; and second, the supervisor did not give the nurses the bereavement notices when she felt they had a work overload. This latter action affected Ruth's view of herself as being independent in her decisions relating to her work with clients.

Ruth's Schools

Ruth was responsible for four schools, Rainier, Helston, Aviemore and Charlecote. Rainier was an elementary school and was a feeder school for Helston a junior high school that had additional opportunity classes with pre-vocational training. These latter classes were open to students from all over the city and so parents of some of these children lived outside Ruth's district. Aviemore and Charlecote were both under the same administration having a principal and secretary in common. Aviemore had two classes, grades one to three and four to six being amalgamated. Charlecote was a specialized school whose curriculum was developed around a Fine Arts core. Children also came from all over the City to attend this school. Rainier and Helston took most of Ruth's time, in part because of their larger size and in part because there were more children with family problems.

Speaking about her schools Ruth explained:

> You could be full time in the schools if you wanted - there is enough to do. Some weeks my home visiting is busy, more often I spend at least one day at Rainer and half a day at my other schools. At Rainer I'm really made to feel part of the staff and I'm used well.

This contrasts with her perception of Helston "It's a junior high and involvement is less there." She went on to explain:

> The population is less stable and the teachers are not as good at referral. I try to have coffee with them, to get to know them so they think of you when a problem occurs. (17/10/79)

Ruth sees high visibility as important in establishing her presence with the teachers. Following the clinic group development session, when she had not been in the schools for two weeks she said: "I must get in for coffee, to remind the teachers I exist." (4/2/80)

In looking at her role at Charlecote she said:

> It's an Arts based school and children come from all over the city - they don't have that many health problems. Last year they had head lice and nearly burnt all the costumes - but we caught it early. I was certainly involved in that! (17/10/79)

The Nurse's Role

The first school I visited with Ruth was Helston. It was an old red brick building, which had had a new wing, with a gymnasium added at sometime. The nurse's room was on the second floor but was near several classrooms. When we went to the secretary's office we received a friendly welcome "Hello Ruth, how are you today? We don't have too many transfers for you today." I asked how many chilren there were and the secretary got out her book and said, "453 as of 4 October". We went to the staff room to check the mailbox and Ruth was stopped by a male teacher who said, "What about Vivienne's glasses?"

> Ruth: It seems her parents don't think she needs them. They don't speak much English and it seems she doesn't speak much Chinese, so communication is a problem. I went out last Wednesday because Vivienne said her Dad was home but there was no answer, I'll check with her and try to visit again.

The teacher responded, "Good, you're still following it up then". There were four referrals in the box and I laughingly said, "You said teachers did not refer much at Helston". "No, this is unusual. I usually only get one or two a day". On two subsequent visits I made with Ruth there were no referrals, so it seems likely that the first day was atypical. (17/10/79) Only two referrals came from the teachers, both requesting vision checks, one note was a parental request for immunization and the last was from a student who was requesting a visit with the nurse. Ruth explained:

> This girl comes from a family with many problems - I haven't actually been into the home but Hazel [another nurse at Eastwood] has - she has children younger than Rosie in Montrose School. The mother lives with a man, not the girl's father. I saw her once last year when the teacher was concerned about her but she went off to Saskatchewan to live with relatives - Metis - but now she seems to be back. (17/10/79)

In this school mental health problems seem to be pre-eminent, and seem related to unstable home environments. Ruth said, "Most of the children I see, and last year I had a teacher too, the one we just spoke to in the staff room, have mental health problems".

> The teacher was having all sorts of problems last year...she had been to a marriage counsellor when her first marriage was in trouble and the word "psychologist" was just a bad scene. I persuaded her to see Elizabeth (the mental health consultant), she saw her several times and finally was able to persuade her to see a psychologist. At first she used to give me regular reports...now she doesn't need to anymore.

Ruth believes her clientele in the school extends to both students and teachers "because if you've got uptight teachers it's going to reflect on the students." I asked her if she saw many teachers. "No, she's the only one except for the vice-principal. The school's split male-female and he's not the male chauvinist type. He needed to sort things out - and I guess I was out of the main stream of things." Ruth sees this type of activity as "building rapport and also it's a kind of mental health activity."

Obtaining a Biography

The first student to be referred for vision testing was Daniel. His vision checked out all right but he lingered looking at the posters. Ruth went over and stood next to him, then she spoke to him.

Ruth: How are things at home Daniel?

Daniel: O.K. (Played with edge of post - standing by couch. Nurse standing with him).

Ruth: How many children are there in your family?

Daniel: Four.

Ruth: Older or younger?

Daniel: An older sister in Vancouver - a younger with my Mum.

Ruth: How old are they?

Daniel: My older sister I don't know. My younger - when I was with my Mum she was seven.

Ruth: When was that Daniel.

Daniel: This year - I was in the detention centre and foster homes.

Ruth: How long have you been in foster homes?

Daniel: Four months.

Ruth: What happened?

Daniel: My Mum and my stepfather had a fight. He was mean - see this scar - he burnt me with a cigarette when I was seven - six maybe. He left my Mum now - my sister is there with her.

Ruth: And your father?

Daniel: He was in the army see? He drove a tank. I was glad when the war was over and he came back.

Ruth: What war Daniel?

Daniel: I don't know. That's all he told me. When I'm 13 I'm going to be a naval cadet. You know the cadets? I saw this advertisement in the paper (voice animated here). (Still plays with poster, does not look at nurse).

Ruth: Where's your Dad now?

Daniel: I don't know. My younger brother is still with my stepfather. I don't know why. He's cruel.

Ruth: How many foster homes have you been in?

Daniel: This time my grandma is OK. She can't adopt me - she's 67 nearly 68.

Ruth: Sounds like you have a lot of things happening to you lately. This can make things hard, hard to think about school work. Do you have anyone to talk to?

Daniel: My fosterparents - and my grandma.

Ruth: Is she your real grandma? Your mother's mother?

Daniel: No.

Ruth: Your foster grandmother?

Daniel: Yeah - I can talk to her when I want to.

Ruth: If you feel a need to talk to someone else, you can always come and see me when I am in school - or leave a message with the secretary.

Daniel: Yeah.

Ruth recognized that Daniel had a need to talk following his vision screening and provided the opportunity. She then attempted to find out more about his background. He showed us a scar on his arm which looked like a cigarette burn. He also had another scar which appeared to be due to trauma. After he had left Ruth commented:

> He seemed to want to talk, yet he was fidgeting and did not look at me. He looked no further than my neck when he raised his eyes. I'm a bit confused about how long he's been out of the home. I think I'll phone the social worker, so I have a better idea of what is going on - why he was taken out of the home and his current foster placement. It's odd, when he talked about his Dad and the cadets he seemed to come alive, yet he doesn't know where he is now. I don't know what to make of his story.

We went to the school office and checked his record and it showed a series of assessments of his intellectual ability plus inpatient treatment in a facility for disturbed children. The fact that he had been burnt by his father some years previously was confirmed in the notes. Then we met the school counsellor who said:

> Yes, we're having trouble with him in school. Even in the special placement class he is hyperactive and will not settle. He disrupts other children and the teacher is getting to her wits end. The foster mother has taken him off his medication - there's a history of petit mal and this needs to be followed up.

Cooperation Among Professionals

Ruth said she would try to contact the social worker as obviously Daniel should be reassessed regarding his drugs. At coffee one morning in the clinic Ruth said to me:

> You know Daniel - the boy we saw for the vision testing. He has been suspended - they couldn't cope with him even in the special placement class. The teacher wanted me to make a home visit but the counsellor, when I talked it over, felt it was unnecessary. There's a social worker involved - so I said if they had any trouble getting him assessed at the Glenrose I'd see if Dr. Chivers (medical officer) could help. I think that that is my most useful role in this case - the medications can't be restarted until after he is assessed, it is really a school rather than medical problem at this point. (volunteered, 27/11/79)

Later in the year when we returned to Helston school Ruth was telling me of the high number of children with mental health problems there had been that year. She reiterated her earlier concern about availability of services.

> Daniel was readmitted to the University Hospital where he is on the child psychiatry unit. Of course he had a history of health problems and treatment, but you wonder where the preventive services are - there are some there, but too overloaded to be of use when needed. (13/2/80)

Daniel shows the need for co-operation among professionals in working with children. Ruth identified a problem which she confirmed with the counsellor. She checked the school cumulative record to verify information. She decided not to make a home visit as a social worker was involved with the family but offered help if there was delay in getting

Daniel assessed. She said, "Sometimes the nurse is in the best position to co-ordinate care if a health problem is involved."

A Constraint to Care

Ruth's perspective on the shortage of preventive services was supported in the case of Rosie, the Metis girl who had asked to see her. When Ruth interviewed her she was obviously depressed and was having problems communicating with her mother at home. The teacher reported that she was doing poorly in her school work and we noted her name on a list of children with failing grades. Rosie was aleady in the opportunity class. She was on the list to be seen by the school psychologist and Ruth asked her to come back the next week to talk with her. "I think she will, she seems to find me helpful, but she needs more help than I can give her." (17/10/79) When she told me about Daniel in February she added:

> You remember Rosie? She "freaked out" one weekend, to quote what I was told, and she is now in the Alberta Hospital. The problem is there is nowhere where you can get help for those kids until they become so sick they have to be admitted. There simply aren't the community services.
>
> I spent an hour or more talking to the school counsellor after this happened. We wondered if there was anywhere we had overlooked. Half the problems here this year have been psychiatric. (4/2/80)

Her frustration with the lack of services is evident. Both Rosie and Daniel were identified as having problems early in the school year, yet there was no adequate ambulatory services to which they could be referred.

Respect for the Individual

That Ruth was known to some students was apparent. Kim stopped her in the hall to say "If you promise not to laugh I'll show you something" and produced her student I.D. photograph. Ruth responded by saying, "It's not very flattering is it", then asked how she was settling down at Helston. Ruth explained to me afterwards that she had got to know Kim last year when she gave maturation classes. Just before lunch, Donna came to get a band aid for her finger. Donna said, "I haven't been ill at all this year" and Ruth explained, "Donna had measles, her tonsils out and flu last year and was away a lot, so I visited at home." Roxanne also came in to talk about her younger sister who had allergies. "The doctor says it's cheese, my Mum gives her cheese in her lunchbox because she likes it." Ruth remarked, "I knew Kim and Roxanne last year and they see me as a link now they are in the bigger school." She decided she had better phone Roxanne's mother. "There could be a problem there knowing the home situation. If the sister is allergic to cheese Mum may still be giving it to her because it's easier than arguing." She added, "I expect Roxanne came up because she saw me get Daniel from the classroom. She had a habit of dropping in frequently last year, usually when I'd seen someone else from her room." Ruth obviously knew the students whom she had seen the previous year and she showed evidence of retaining a biography from one year to the next. Ruth commented, "In a school this size you only get to know a few kids - and they're generally the ones with problems." As we left for lunch, the vice-principal met us in the hall and asked Ruth to see Terry Primeau, "She's got all sorts of complaints again, her mother says she retains fluids before her period and I said I'd ask you to talk to her." After he had left Ruth said, "I discussed the fluid retention with the Mum last year - but she's more talk than action. She probably had her to the doctor several times, but has done nothing with the advice." She decided to follow up her next day in Helston. "It's not urgent at this point."

A Conflict of Interests

The principal at Helston was not particularly communicative on the occasions that I saw him. An event that threatened to shake Ruth's credibility occurred while I was with her at Helston - the health inspector closed the lunchroom. Ruth was called into the principal's office and asked what she knew about this. "It seems someone reported we were serving foods illegally and that the conditions were poor." There was the insinuation that Ruth had been responsible. She replied, "I know the inspectors were concerned that food was being served under unsatisfactory conditions in the schools and that several schools have been inspected." (17/10/79)

Later I asked Ruth if she had followed up the closure of the lunchroom with the principal. She said the public health inspector told a very different story from the principal, so she decided not to discuss the issue with the principal again unless he raised it. "I have the feeling Mr. James was trying to make me take sides and I think keeping out of it will cause the least damage to my rapport". (19/10/79) As the closure resulted in the provision of better facilities for the school by the School Board, Ruth's decision seems to have been appropriate.

Health Teaching

In November Ruth was called to Aviemore to examine the children's heads for "mechanized dandruff." A family that had just left the school had been found to have head lice and as they had also shared accommodation with a family who attended Aviemore it was necessary to examine the children's heads. As children from the contact family had been in both classrooms it meant examining all 27 children who attended the school. Ruth took the opportunity, despite a terrible cold, to enquire about the children's health. Before examining the younger children she said, in explanation, "I just want to check through your hair and see if it's nice and clean - it won't hurt you any."

She noticed Terry (an eight year old) biting her nails and enquired:

Ruth: Are you worried about this?

Terry: No.

Ruth: Do you always bite your nails?

Terry: No - not often.

Ruth: Well, how come you're doing it now? Are you nervous?

Terry: Nope. Just need them shorter.

With all the children she saw she enquired about absence from school that year, their normal bedtime and their breakfast habits. When she saw Jason she found his hair to be matted together.

Ruth: What's this you have in your hair - has someone thrown a bowl of porridge at you?

Jason: Glue.

Ruth: Glue?

Jason: Yes I've been making paper mache animals.

Ruth: What kind of animals?

Jason: Baseball animals.

Ruth: What do those do Jason?

Jason: You throw them at people - so you can hurt them. You throw them real hard.

Ruth: What would that do?

Jason: Hurt them.

Ruth: Do you really mean that. I wouldn't want you to hurt anyone. Maybe you need to think about that for awhile. Do you really want to hurt someone else?

Here a social conversation led in a direction that Ruth perceived as problematic. She asked Jason to reflect on what he had said and to consider the implications of his "tough-guy" attitude. However she did not consider whether Jason's comments could reflect a deeper problem. With Sandy, Ruth noted: "You've got some cracked lips there, are they sore?

Sandy: Nods.

Ruth: Are you putting anything on them?

Sandy: Vaseline.

Ruth: That's good. You have a cold?

Sandy: Yes, I just got it.

Ruth: Does it hurt when you breathe - in here? (touches Sandy's ribs)

Sandy: Nope, it's just runny.

Ruth: Have you had any medicine?

Sandy: Nope. My Mum may give me some.

Ruth: You're feeling okay to be in school?

Sandy: Yes, it's just my nose.

Here Ruth asks several questions to ascertain the severity of Sandy's cold. Her replies indicate that she is caring for her cracked lips and that she sees her Mother as responding if needed. Ruth is satisfied from her responses that "her mother knows what to do if necessary." Carlotta indicated she did not have an adequate breakfast and that if she got up late she went without. Ruth suggested:

> What about - if you're late getting up - could you make a peanut butter or cheese sandwich? Or take an apple? Bet you're hungry by recess and not thinking about school!

As she combed the heads she also chatted to the children following up previous contacts. Darna had had impetigo and she enquired about her siblings, "Is everyone else at home all right now?" She also asked about the children's friend, the contact family, who had recently moved. With John, the little Korean boy whose father we visited, she enquired, "Did you have your tooth fixed?" and asked if he knew which school he would attend when they moved. Ruth knew the children and responded to them as individuals, they seemed at ease and answered her questions readily.

When she got to the Grade IV and VI children her explanation of the procedure changed. "Do you remember I had to comb your head last year? I have to look for nits - the eggs of lice." When Linda came in she announced, "Mother thinks I may have nits, my friend had them". When Ruth examined her she did find some.

Ruth: Have you seen a nit?

Linda: No.

Ruth: See this little white piece, it looks like a bit of dandruff, but it's stuck to the hair. Now, you have to wash with a special shampoo, that will unstick the nit from the hair. Tell your Mum, when she scrubs to really have a go behind your ears - here (outlines on Linda's head). Also she needs to wash your sheets and pillowcases and anything you have on your head. I found a few in Darna's hair (younger sister) but I did not tell her, so she will have to be shampooed too. I will give you these written instructions for your Mum - but I'll give them to the teacher so you don't have to walk back in class with the envelope.

Linda: It's okay. I'll tuck it in here (undershirt).

Ruth: Fine.

Ruth gives Linda the information she needs both to understand and cure her problem. Linda's friend, Jenny, John's older sister, was the only other child to have nits. Because Jenny's parents did not speak English Ruth got her to repeat the instructions she gave her about the treatment. She also wrote down the name of the shampoo. Ruth talking of her activities on this occasion said:

> I think this [counselling] falls into the prevention angle...in cases where kids were not eating breakfast, it was an attempt to give some information to try and correct that particular problem...rather than things being basically okay and adding to that. (18/2/80)

On another occasion she noted Gerald, a twelve year old, placing his glasses with the lens downward.

Ruth: You know what you shouldn't do - put the glasses down this way (places with lens up) do you know why?

Gerald: No.

Ruth: Because you'll scratch them if you put them with the lens down. Will you try to remember?

Gerald: Okay.

Ruth again acts on her belief that it is important to teach clients about matters related to their health care. She bases much of her teaching on her observations of the situation, noting inappropriate behaviour such as Jason's expressed hostility or Gerald's care of his glasses.

Professional Liaison

When Ruth spoke of Rainier School she said, "There is excellent co-operation here between the Principal, the Counsellor and myself." (19/10/79) On arrival the principal greeted Ruth saying, "Ruth, the little Ledoux girl is still complaining of earache." Ruth said that the mother had planned on taking her to the doctor and the principal commented, "They're so keen on being in school now, perhaps she didn't want to miss - with both her and her sister the record is very different from last year." We went to the nurse's room and before Ruth had time to take her coat off there was a knock on the door. It was Sharon Ledoux. "My ear still aches." Ruth examined her ear and noted it was discharging. She found that Sharon had had penicillin prescribed and was to return to the doctor that day. She told Sharon she would telephone her mother, "Because it's certainly important you see the doctor again." For the next half-hour Ruth organized charts, filling out requisitions for children who had transferred into the school and pulling the charts of those who had transferred out. When the bell rang we went to the staff room for coffee. The principal was there and Ruth told him of Sharon's visit and her planned action. The school counsellor joined us and immediately started to give Ruth a report on children he was concerned about that day.

> I wanted to talk to you about a couple of families and bring you up to date. Tod's mother was in and she's at her wits end - she seems ready to put Tod in a foster home at this point. He was at the sink and wielded a knife and raised a welt on the younger child.

The counsellor then filled in the family history, suggesting Tod was abused by his step-father. The principal said, "Jim, [the counsellor] offered to go over at the weekend, but his mother [Tod's] says he just drinks [stepfather] and it would be no good. The principal then said:

> I think the situation has got to the stage when we need to get Tod seen [by a child psychiatrist] maybe. Mother I'm sure would agree at this point.

Ruth added, "The quickest way to go about it is to get Dr. Chivers [the clinic medical officer] to do a physical then a referral could be made."

Principal:	If he was admitted to the school hospital it would give things time to settle at home - then Jim could keep on working with the family. Sometimes it helps the child, somtimes it doesn't.
Ruth:	But at least it gives the family a break.
Principal:	Yes, and that in itself often helps. He may still need a foster placement.
Ruth:	[To counsellor] If you get permission from the mother, I don't know her and you obviously do, I'll arrange for an examination by Dr. Chivers.
Counsellor:	I'll do it this morning and get back to you.

This situation demonstrates the co-operation that Ruth perceived to exist between the principal, counsellor and herself. By noon that day arrangements were made for Tod to be seen the following Monday and on Ruth's report of the case Dr. Chivers also initiated a referral to the child psychiatrist, so there would be minimal delay. Ruth remarked, "You really feel at this school they are concerned about what is best for the child."

The vice-principal at Helston would also contact Ruth about students when she was not in the school if he had concerns. He called clinic one afternoon (19/11/79) to ask her to make a home visit on a girl who had been absent for thirteen days. The mother was not home much of the time, the father was supposedly "up North" but the telephone was answered by a man. There was some suspicions that there might be a possibility of child neglect, so the school wanted the nurse to investigate. "We usually go out first, if there is definite evidence of neglect I would refer to child protection. If the problem did not endanger the children I try to work with it first." I enquired about the social worker's role, "Well, I find they're so busy that if it's not actual abuse the family would be 54th on their list, so if I feel I can help I'm better to stick with it."

Health Promotion

Ruth taught a kindergarten class about nutrition, "which is health promotion". She showed Canada's food guide and asked the children to name the foods pictured on each different colour on the poster she was using. The children wore name tags and when she spoke to them she called them by name. When they answered she responded, "Well done Robert", "That's good Jean." After discussing energy, Ruth used a snack poster with a sad face and a happy face. "Sad snacks don't make you grow and don't give you energy". Following the introduction Ruth used a game of musical post office to reinforce the information. There were three boxes containing food pictures. When the music stopped the children nearest each box picked a food, then placed it on the correct position of the Canada's food guide poster, which was in the centre of the circle. Ruth had invented the game and the children participated eagerly at first. In evaluating the class Ruth said:

> I needed more boxes, there were too many children for the number I had. There were some who really concentrated, but it was hard to know who had not understood. They were eager to answer the questions

> at the beginning, I do like to try and call them by name, make it personal, but again it is hard with a big group.

In looking at what she would do in the future she commented, "I'd use more boxes so it didn't drag out so long. It outlasted their attention span." In her choice of activities, her level of content and her evaluation Ruth demonstrated the application of her knowledge of child development to the planned activities.

Administration Tasks, Phone Calls and Records

In the early part of the year I did not go to Charlecote with Ruth "It's a different school, the teachers are independent and don't need or look for resource material, although there is an emphasis on health in the curriculum." When I did visit the school (31/1/80) the corridors were filled with paintings. One display in particular caught my eye, a series of drawings and studies entitled, "Going to the Hospital." It was obvious that the topic had been discussed in class and one suspected that many of the children also had had first hand experience. Ruth commented, "That's the sort of display you see, the curriculum is centered around Fine Arts and the content is organized around this."

The children were all appropriately dressed for the cold day outside and came up to us when they came in from recess to chatter about themselves and the weather.

> Parents here are often "arty", that is connected with the cultural scene. They may drive from as far away as Sherwood Park [15 miles] to bring the children here. Although I have more children here I spend more time at Aviemore because they have the problem. It is low income, new immigrants -, here most of the parents are the type who pick up problems long before the teachers feel it necessary to let the nurse know so she can talk to the parents.

In checking the health records it was evident that parental occupations fell predominantly within the artistic or professional categories, there were teachers, a reporter, an artist, an art gallery manager, a stage carpenter and an air traffic comptroller. The two days I visited the school there were no referrals and the time was spent on completing records after visual screenings and contacting parents in cases where follow-up was needed. After attempting to call three parents, Ruth remarked.

> No one wants to talk to me today! I'm trying to follow-up a vision suspect from screening. Mum needs to take him for testing. I must check if there is a work number. Preparing for screening takes time and then there are the follow-ups. (7/2/80)

She did find a number but the mother had left that employer. We were given a second number but she had moved from there and finally we located her at a third number. Fortunately the previous employers knew in each case where she had gone next. In the lower income groups this was rarely the case and tracing a client was often impossible.

Ruth said:

> I like to try and make my contacts at work...if I need to make some evening telephone calls or something like this to catch up with people, I have a very difficult time remembering to do that because once I get home it's sort of over and done with and I don't really think about it a lot until I get back to work the next day. (27/11/79)

Ruth needs her energies for both home and the job. When she is at work she appears to put her full energies into her work, as evidenced by her use of the opportunity to find areas where health teaching was needed the day she combed heads at Aviemore. She had a bad cold and had originally planned to go home early, if she had merely combed heads, she could have done so. Commenting on her work she said:

> I was glad to get the district I did. I'd had enough of no-shows and finding families and dealing with multi-problems. It was a relief to get into a relatively stable area. (6/2/80)

While Ruth was working on her records I began to understand some of the frustration that the paperwork created. She showed me one record:

> This record has just come in. The requisition went to Fulton Place and they said they didn't have it. Then it went to Grande Cache then to Idylwylde back to Fulton Place and then to Central. That's the trouble when people move so much - it takes time to trace their records. I've been waiting five months [October to February] for this one. (7/2/80)

Then Ruth had a problem with the consent that had been signed, but the child's name was missing.

> By a process of elimination I got it right, Marian Robbins is the mother of Roxanne Curtis. The mother reverted to her maiden name - she remarried but did not change her name. It's awkward when you get one like that - you have to see whose consent is missing and then remember what you know. (7/2/80)

Here Ruth again shows her ability to synthesize her knowledge of clients into a biography. For some nurses obtaining consents is a time consuming business because parents move from out-of-province and there is no blanket consent. For Ruth this is not really a problem. "I don't really have that much trouble getting consents, most of mine are signed."

Assessment of Clients

In this school Ruth has good rapport with the teachers although there are few referrals. We went over a class list with the Grade I teacher and compared to other schools she reported few concerns, yet she was alert to problems pointing out one child whom she felt might have visual problems and another who had a broken arm. In relation to another child she said, "He has had a lot of colds but his mother has taken him to the doctor." The interview seemed to support Ruth's observation that parents took care of the childrens health needs before the teacher had a need to call in the nurse.

Ruth also rechecked the vision of four students who were borderline the previous year. "I see vision screening itself falling into the prevention realm. It's a case of trying to pick up problems rather than promoting anything. I think while you are screening it provides a vehicle for more of a promotion angle though." On the day I observed her Ruth asked the four girls about their health, as measured by their absence from school, and found no problems, but asked no further questions as she had done at Aviemore when she was combing heads.

Summary

School nursing for Ruth involved many activities ranging from case-finding, through referral, guidance and counselling to classroom education. Most activities would seem to fall within her definition of prevention but her nutrition teaching was a health promotion activity. Educational activities were obvious throughout her encounters with the children and she frequently used her personal observations to identify a specific need. She saw her activities differing in each school once the standard programmes were accomplished, although in both Helston and Rainier referrals tended to be related to children with emotional problems. In the schools the attitudes of the principal dictated the way in which she was used but a difference in the social and economic background of parents also resulted in different health needs amongst the children. In all schools Ruth tried to maintain a high visibility with teachers and always joined them at coffee breaks. It was obvious that they were aware of her and her function in the school although they did not always use her services.

The Clinic

Ruth, on the average, spent more time in the clinic than either Carol or Kate. She felt this was because her home visits were less numerous. I asked her what she looked for when mothers and babies came to clinic.

> I suppose I look to see if [the mother] is coping well with the various areas of her life...that she is able to cope with looking after the new baby...after the household tasks that she has...that she's able to anticipate some of the things that may come up [in the future] and have resources available to react to those situations.
>
> I look at the ease with which she is handling the baby...confident moves instead of sort of jerking...the cuddling that goes on.... Perhaps the type of thing she is expressing verbally [she may show] hesitating or lack of confidence. I try to assess whether she is able to look after the baby and feel comfortable with her own level of skill in doing so.

Assessing Family Function

How Ruth used these criteria of judgment was shown in a visit with Louisa and Ebony Lubbertz. Louisa, a seventeen year old single parent, brought her two and an half week old daughter Ebony into the clinic because the baby had been crying and unsettled. Ruth introduced herself and then the researcher and permission was obtained to tape the session. Ruth proceeded to get a history of Ebony's feeding patterns. It appeared the baby was taking up to eight ounces of Similac at some feedings and that morning Louisa had started her on Pablum. Ruth started to examine

Ebony and removed her diaper. In the middle of the conversation Ebony started screaming.

Louisa: What's the matter? What's the matter with granny's girl?

Ruth: You'd better hook that back up [a plastic diaper holder] and get it on right - I don't know how it goes.

Louisa: What's the matter eh? Been cranky all day for Mum haven't you. She sleeps O.K. She sleeps most of the night. Last night she went to bed at 12:30 - but she never woke up until 5:30. It's a good piece of sleep for me (laughs). (To Ebony) You're mad at Mummy aren't you?

When Louisa had finished putting the diaper on she picked the baby up and cuddled her and she quieted down but then Ebony started screaming again.

Louisa: Want your soother? Tckk, Tckk, (clicks tongue at Ebony).

Ruth continued to question Louisa about Ebony's feeding patterns, her stools and whether the formula had changed. The information was somewhat conflicting but it seemed Ebony was taking about forty ounces of formula a day.

Ruth: She shouldn't be drinking that much.

Louisa: That's what my Aunt told me - she said to try giving her some Pablum, - but, um, I'm not too sure. I only gave her a little bit.

Ruth: How much did you give?

Louisa: Just a teaspoon. (To Ebony). Do you want your bottle? Do you want your bottle? (Opens bottle, croons at child). What's the matter? Have you pee'd in your diaper? No! (Baby continues to cry).

Ruth admitted that the way Ebony was crying "seems to indicate she's reacting to a discomfort of some sort" but "it's difficult to pin it down to a specific". She enquired about the frequency and consistency of the child's bowel movements, trying to obtain more information on the cause of Ebony's distress. Louisa concentrated on Ebony and encouraged her to take the bottle, "You want your bottle now? Mummy will fix your bottle." She then said to the nurse, "You see, she more or less seems to be looking for it if she cries." Once again she turned to the baby, "There, there, there." In evaluating the visit Ruth assimilated her observations in making an assessment of the situation.

> I think she's very concerned about the baby...and certainly was trying to comfort the baby when she was crying...and seemed quite free about cuddling the baby. She seemed though to feel some insecurity "the baby's mad at me" - taking things very personally, and wondering "am I doing the right thing"...Feeling a bit inadequate perhaps and not really feeling sure about what she was doing. She seemed as if she would be quite open to have people talk things over with her. (9/11/79)

Ruth decided to refer Louisa to the district nurse in her home area. She found that the child had been handled by a variety of visitors and even after many questions to Louisa, she was not entirely sure what Ebony's feeding pattern entailed. She cautioned Louisa not to use Pablum in place of milk but did not suggest she discontinue its use, although agency policy suggests withholding solids for three months.

Conflict with Agency Policy

In speaking about advice for the mother, Ruth explained that she was conscious of the agency feeding guide and "what we tend to recommend" but, "in some situations I will throw that out of the window." She explained, "I weigh the odds of the theories as to when the child should be placed on solids against the immediate needs of the situation." (18/2/80) She identified three ocasions when the situation took precedence, "If the baby seems to be really hungry, if it's not sleeping well", or "if the mom needs to get some sleep". With Louisa another concern was identified "as she seemed insecure I didn't want her to feel she had done anything wrong."

> If I feel that the benefit to the mother and the baby at that point in time would be more if the child were given Pablum, then I would say "go ahead and give the Pablum" as opposed to sticking rigidly to the feeding schedule. (18/2/80)

Ruth has had more experience in public health than any of the other subjects. She is very aware of procedures but seems able to balance them against the immediate situational needs. Another example of this is the area of advising parents on care of the child following immunization.

I was told by several nurses that advice on medication had to be referred to the physician as some doctors preferred Baby Aspirin while others prefer Tempera. However, some mothers are reluctant to telephone their doctor and so do without. One such mother was Mrs. Doyle (19/4/79) who had Shaun in clinic for his second immunization. She was fashionably dressed in calf-length skirt and high boots and appeared to be economically more stable than most mothers who attended the clinic. Ruth asked her the usual questions about Shaun's progress, then said, "Any other questions or things you're worrying about?"

Mrs. Doyle:	I was wondering for tonight, like last time [after the immunization] he was getting a little bit warm..../
Ruth:	Okay/
Mrs. Doyle:	and the nurse said if it didn't break after about eight or nine o'clock to phone the doctor/
Ruth:	Okay/
Mrs. Doyle:	but I didn't like to because he wasn't too bad but I was thinking if it did happen [this time] could I give him something?
Ruth:	Do you have anything at home?

Mrs. Doyle: No. I didn't want to get anything last time because I hadn't checked it out.

Ruth: Right. Commonly Tempera drops or Baby Tylenol are used for babies and they're liquid preparations and we just give them with the dropper - or you could use half a children's Aspirin and just crush it on a spoon.

Here Ruth does not give direct advice or say "use this" or "use that" but provides the mother with information that will enable her to make an informed choice on appropriate medication if it is needed. The mother asks about a preparation called "Baby's Own".

Ruth: Baby's Own you may need to watch, it may act as a laxative as well. It has many things it will work for like fever, teething, as a laxative - but it is more for a straight ache type of medicine. If he has a tummy ache perhaps some gripe water and a drink of water would help - but you need to be careful with Baby's Own.

Ruth is again careful not to say "do this" or "do that" but her opinion comes across clearly in her guidance at this point. I asked her how she knew her teaching was effective.

> You really never know whether you effected any change in behaviour or not. I think probably a lot of it comes from immediate feedback from the mother as to whether she understands what I am saying....Like I won't see the effects probably of what I am doing right now, but the nurse that follows me will see what I have done, and I see the things that have come out of what the nurse ahead of me has done. But in some ways it is hard to evaluate what you are doing. (18/2/80)

A Problem of Conflicting Information

Mrs. Mazola brought Amanda to clinic at eight weeks of age for her first immunization. She had been in at six weeks to have her weighed and to discuss feeding. Ruth had commented:

> I think in clinic I tend to initiate more questions or things that I ask about and I think that the mothers tend to sit and wait for you to ask questions...while in the home setting I tend to follow along more on concerns of the Mom and things she brings up. (22/11/79)

This tended to be true in the area of history taking but early in most interviews Ruth would ask, "Do you have any particular questions or concerns that you were...? Mrs. Mazola said, "She has a lot of really bad stomach aches all the time and I was just wondering what caused it?" This did lead to a string of questions on type of formula, amount fed and the frequency of feedings. This led to feedback from the mother on advice she had received at her last visit.

Ruth:	What kind of milk are you using?
Mrs. Mazola:	Homo.
Ruth:	You're using homo milk - are you diluting it with water - or just straight?
Mrs. Mazola:	Just straight - I was giving it with water until last time we came to clinic.

The guidelines suggest that homogenous milk should be diluted until six months of age. The nurse had charted at the previous visit "Advised on feeding - using homo milk", so no information was available to Ruth on what advice was given.

Ruth:	Um...yeah...because normally, I'm not sure why they'd suggest not diluting it...er...because normally we suggest until they are six months of age it really should be diluted...in the proportion about 26 ounces of milk to six ounces of water, to give you a day's supply. It isn't a lot of diluting but it does seem to make it easier for some babies to digest it....and if it's causing problems...er, did she seem to be better having diluted milk?
Mrs. Mazola:	Well, I only had her on it about two days.

They continued to discuss the switch and Mrs. Mazola said she felt Amanda had had no problems on Enfalac but that she could not afford it so she had changed, despite the doctor's suggestion that Enfalac should be continued for six months. Ruth was quick to respond saying, "Babies can certainly get the nutrients and things from homo milk." She then suggested that Mrs. Mazola dilute the milk, "The cow's milk is more difficult for them to digest because of the fat and proteins that are in it. Diluting the milk quite often makes it easier for them to handle." Mrs. Mazola did not respond to this and after a pause Ruth asked about the baby's stools. After assuring herself that there were no problems she again returned to feeding "I think if, as I said before, you try the diluted milk, for several days to a week's time." She then suggested if things did not improve Mrs. Mazola might want to see her doctor as a medication or change in formula might be required. "Does this sound reasonable?" Mrs. Mazola said "Yup - I'll try the dilution and see how she does."

Ruth was obviously taken aback by Mrs. Mazola's interpretation of what she had been told at the clinic. However she could not assess the accuracy of the client's statement because the record did not provide sufficient information. When Ruth charted at the end of the visit she wrote, "Advised to use dilute homo 26 ounces to six ounces of water." She also wrote this out for Mrs. Mazola. Ruth also asked if she might drop in to visit when she was out in the district as Mrs. Mazola lived in her area. "I got the feeling that she was trying to be very cool, calm and collected on the outside, but not quite so much on the inside, and she really doesn't have much of a support system in the city." In this case Ruth felt that the feeling tone of the interview did not correspond with the surface behaviour of the client.

Explaining the Procedure

It was noticeable that when it was time to immunize the baby and Mrs. Mazola asked "what's it for?" that Ruth gave a detailed answer:

> What is given for the first part of the series is one needle for whooping cough, diphtheria and tetanus and we give the oral polio vaccine - that's just a drop on the spoon. She gets three doses of that so it will be December and February, they're two months apart. She would get the measles vaccine at one year and then there's a booster for all this at eighteen months.

Ruth pulled out the leaflet which outlined the programm. "This is what we start on, these three doses".

> The usual type of reaction, to the immunization, [is] a red and tender area on the arm, right around the site of the injection. If it seems quite warm or tender to touch for the baby, put a warm compress on it, using water that feels quite warm to your hand, but not warm enough so it's going to burn her...just a wet facecloth or something like that with warm water and hold that on the arm. The heat helps to ease it. Also, if she has a slight fever you can give her something like Tempera drops or there's baby Tylenol or children's Aspirin. You can also sponge her all over with lukewarm water, wiping of the excess, but basically letting her dry in the air. If there's going to be a reaction it usually occurs within 24 hours of the immunization.

Again Ruth handed the mother a printed slip of paper which outlined common reactions and asked, "Any questions from that?" To which the mother replied "Nope". With a mother's first baby Ruth generally uses an explanation similar to this one. With second immunizations she checks previous reactions and reinforces teaching when necessary, but the explanation is adjusted depending on her estimation of the mother's understanding of the problem.

Meeting Mental Health Needs

When Ruth was speaking to a group of student nurses as part of an orientation to public health nursing she said:

> Mental health aspects of the job are part and parcel of what we do. We don't follow up for [psychiatric] discharges, we look at mental health as improving the family's environment and helping them attain a healthier life style. (4/10/79)

With Mrs. Mazola Ruth was concerned because her husband was away a great deal in his job and she had no friends in Edmonton, she suggested:

> There is quite a baby boom on your block. Perhaps you could get together and do some babysitting in turn. This would be one way to make friends. Do you know the caretaker? I visited her the other day.

Mrs. Mazola did not know the caretaker to speak with and did not really respond to the suggestion. Mrs. Mazola had also told us that she spent too much money on telephone calls to her family in the Maritimes, "But I get so lonesome to speak to them". In evaluating the session Ruth stated, "From my initial visit I got the feeling she was isolated and somewhat lonely and that can be devastating if you have a new baby." Here again Ruth blended previous experience with her observations and expressed concern about the client's lack of support system. She then planned the home visit mentioned earlier.

Active Involvement of the Client

When Ruth was describing the clinic she said, "most days I would see some adults but mostly children" and this proved to be the case. Most of the adult clients came for travel immunzations, mantoux testing (for tuberculosis) or influenza vaccine. With an adult requesting immunization for travel Ruth always went over the travel brochure with the client, identified the countries he or she would be visiting and then got out the latest international immunization requirement circular and checked that with the client. "Sometimes they come in having been told one thing by their doctor and another by the travel agent and this way they feel secure that they've had the right thing." With clients who are going to a country where there is a risk of a malaria Ruth explains the procedure:

> There is a malaria risk. You have to get medication from your doctor. You start taking the pills at least a week before you leave, you take them on your trip and continue for a few weeks afterward. (15/10/79)

With adults Ruth also explains the purpose of the test and its reaction. She asked one client if he knew what the mantoux was for and he shook his head.

> This is a mantoux test to see if you have been exposed to tubercular bacteria. I give it on the inside of your forearm and it will make a little bubble. If you react you will get a raised red area. I need to look at your arm in forty-eight hours, which means you have to come back on Wednesday. (15/10/79)

Respect for Others

Another client, Beauty Robertson, returned to have her diphtheria test read and was to be immunized. I had seen her receive the test and observed she had nearly fainted. Because of the type of record this information was not charted, so I mentioned it to Ruth. She immediately went around the clinic to find a combined diphtheria and tetanus vaccine to avoid giving two needles. As it happened the clinic was out of stock of that particular combination. Ruth was apologetic:

> I'm sorry we'll have to give you two needles - but I'll do my best to see we have some combined the next time you come.

Mrs. Robertson did react to the needles by sweating and feeling faint, but thanked the nurse for trying to avoid giving her two needles. This is an example of concern for the individual that was evident in Ruth's nursing. Ruth believed in the importance of mutual respect between the nurse and the client.

> If the client doesn't respect me and what I stand for as a public health nurse..then I don't feel that I can do very much for that family...until I gain that respect. If I don't respect the person I am visiting with and respect some of their rights and individual differences from the last person I saw I don't think I will get very far because they will be able to feel it during our interaction.

In part her response to Beauty Robertson illustrates her acceptance of individual differences. She acknowledged her abnormal reaction to a needle and attempted to find a solution. In her interaction with babies Ruth also demonstrated her respect for them as individuals. When she was examining Moira Dunn, an eight week old baby, she talked to her constantly.

> Yes, that's good eh? I know - I know. Show us that nice big smile. A stretch eh?...You've got a nice skin...How about this? Can you get it? Where are you going? My goodness you do wriggle!

With Ebony when she was examining her she said:

> There, there you don't like that do you. So much handling by a strange person. We'll get Mum to put your diaper on again.

Ruth did not use the baby's names when she spoke to them, but her handling of the child was always gentle and assured. I observed several occasions when she calmed a baby by holding him, but she was aware of what this could do to the mother, "I don't like to calm the baby if mother is having trouble, I don't want to make her feel more inadequate if she already is [feeling this way]." Here she demonstrated her respect both for the mother's feelings and her current level of competence.

Assessment of the Client

Ruth had explained that she based her advice/teaching on her assessment of the client. She felt that she obtained much of her information through questioning. This was certainly evident in the interviews. This created some problems for Ruth in the clinic setting where visits were made on an appointment basis.

> [At home] I can spend an hour and a half on a baby visit if it seems to require it...in clinic I find the time restrictions difficult at times and if you have a Mom having some difficulties the ten minutes allotted for that person doesn't give you time to deal with their problems and I find that restrictive. I guess I tend to go ahead and take the time but that concerns me in that I'm shifting the load onto other nurses. (22/11/79)

The same afternoon that Mrs. Lubbertz brought Ebony into clinic, a visit that took forty minutes, Mrs. Heston came in with five day old Robert. Ruth introduced herself and added "You must have come here straight from the hospital (laughs). What was your concern?" (9/11/79)

Mrs. Heston:	I was just wondering whether he was coming down with a cold. He hasn't been eating very good - he's been spitting it up...and um, he seems to be congested in his breathing.
Ruth:	Are you breast or bottle feeding?
Mrs. Heston:	Bottle feeding.
Ruth:	And when you're giving him a bottle does he have to stop feeding to take a breath...or is he able to still keep sucking.
Mrs. Heston:	Still keeps sucking...but he stops a bit...but he doesn't pull back.
Ruth:	You haven't noticed a big gulp of air or anything?

Mrs. Heston: No - its really just he stops eating.

Ruth: I can hear him breathing - it sounds as if he has mucus in his nose. Did you notice it while you were in hospital still or since you came home?

Mrs. Heston: Just since I've come home.

Ruth: Do you find it dry - do you have a house or an apartment.

Mrs. Heston: Apartment.

Ruth: Do you find it dry when you wake up?

Mrs. Heston: We have a humidifier on.

Ruth explains that babies need additional moisture and suggests a steamer may help in the baby's room.

Ruth: I've got a light here and I'll have a closer look and see. (To Robert) I'll see if I can see anything in your nose. It looks quite clear actually. (Looks again). I can see a little bit of mucus up there - but its fairly high up - beyond the point where you can really clear it out. With a Q-tip, or whatever, you should barely put them inside the nose. You can see, particularly on this side, there's a kind of dried piece, which is probably making it difficult for him to breathe. Let me see if I can get at it myself. (murmurs to baby), yeah, there we go. We'll get you to sneeze if nothing else...you haven't got much room to get this thing in. (Baby cries) No! I don't think we're going to get it. No! Atchoo!

Ruth then explained to Mrs. Heston that if the Q-tip is too big an orange stick with a "wisp of cotton at the end to pad it could be used." Also, "just inside the nose passage a little piece of vaseline to preserve the moisture", will, she explained "ease the breathing as well." Mrs. Heston then asked, "So there's nothing with him spitting up that much?" Ruth asked if that had occurred only today, what he was taking, about how much he had brought up compared to the total feed and the frequency of feedings. All Mrs. Heston's responses conviced her that there was nothing abnormal occurring. She checked on whether Robert seemed fussy or drew his legs up (indicating discomfort) after feeding and how he was burped. Then she realized that that baby had supposedly been seven pounds eleven ounces on discharge and was today six pounds, eight ounces. Without a birth notice she had no verification of the discharge weight. She began to examine the baby. "His skin isn't loose, his face is well rounded, his abdomen is full - he just doesn't look like a baby that's losing weight."

Ruth turned to the researcher and said "Peggy-Anne what do you think - can you help me out at all?" I agreed that the baby did not look as if he had lost much weight and suggested she check the fontanelles, these were not depressed, so dehydration was not indicated.

Ruth: I can't believe he's lost a pound, you would notice some pretty drastic changes. If you want to come back and reweigh him and don't get particularly concerned at this point...he just doesn't look like he's lost a pound...somewhere perhaps its just an error in weight either at the hospital, or something's not working here. [The clerk] mentioned that she weighed him twice.

Mrs. Heston: You mean the weight is wrong.

Ruth: Well, he just has not the physical appearance of a baby that has lost a pound. How do you feel about leaving it and and bringing him back - are you still concerned? You haven't noticed a drastic change in his size?

Mrs. Heston: No.

Ruth: You would notice if he had lost that much - in the weight when you lift him. And he'd look thinner to you too. In a baby this young it makes a lot of difference...and he seems so well filled out - he just doesn't reflect weight loss. Anything else?

Mrs. Heston returned to her concern with Robert's blocked nose and Ruth reiterated the need for steam and vaseline and suggested she tickle his nostrils to make him sneeze. Ruth enquired how Mrs. Heston was feeling, what her support system at home was like and then discussed her lochia. Mrs. Heston enquired about the origin of hicupping and Ruth supplied a detailed explanation. She reassured Mrs. Heston that she could call for help anytime.

> If we can be of any assistance give us a call anytime that you have a problem. I know its a sort an uneasy feeling when you get home and you're totally responsible for that baby and what's happening to that baby...a lot of it is trial and error, to find out what is best for the two of you, what the different cries mean...before long you know which one means I'm hungry and which one means I want to be picked up and cuddled...the different messages get straightened out.

Here Ruth manages to convey to the mother the feeling that she is competent while reminding her help is available if she needs it. Mrs. Heston got up to leave, but again expressed concern about the baby's stuffed nose. "I'm just concerned about getting rid of it". Ruth said, "We'll try it once more - maybe we can get some relief yet" She wet a Q-tip and inserted it gently, the baby yelled, "You don't think much of that - there...there, it's tough isn't it." She then spoke to the mother and Robert started to sneeze cleaning his nose of loose pieces of debris, which were yellow in colour. After several sneezes his nose sounded clear. Ruth showed the mother again how to stimulate a sneeze and added, "with the discharge - I think from the colour that was in his nose since birth, but if it remains coloured contact your doctor on Monday, because that might indicate an infection." She added, "I think it will clear now, he's certainly breathing better."

Mrs. Heston: He dirtied his pants.

Ruth: Yes, he sure did. It smells like a pretty healthy diaper full. (As the mother changed him). It looks quite normal to me.

As Mrs. Heston was leaving she remarked, "I sure feel better". Ruth responded, "Good, that's what we're here for after all." This interview lasted over an hour and Ruth indicated she felt guilty about this as, "it was quite busy outside [in the waiting area] by the sounds of things."

> I felt I couldn't cut things short, the Mum seemed quite unsure of herself, how to handle the baby and what to do with it. She seemed concerned and emotionally attached to the child but just didn't know how to act to relieve the situation. The fact she came here shows she recognizes she doesn't know what to do and is willing to seek help with decisions. I get the feeling Mum's around and I can phone - but she either isn't comfortable phoning Mum and asking questions - or perhaps not a close relationship between the two.

In this case, Ruth had had to deal with two sources of conflicting evidence, the baby's purported weight and her own observation. Because of the conflict she sought a second opinion, in this case that of the researcher. After the visit she commented, "The weight loss doesn't make sense to me". Then she added "Maybe I should have checked him again to be sure - but on the basis of his appearance and Mum not noticing any change - I think reweighing in a week will be okay."

Administrative Breakdown

Ruth decided to send an urgent referral to the district nurse to follow-up Mrs. Heston, but when I checked a week later she had not returned to clinic and it appeared she lived out of the Greenfield Clinic area and so the referral had been sent to Central Clinic. The referral on Mrs. Lubbertz had also failed to reach the appropriate nurse in Greenfield Clinic, as I discovered when home visiting with Kate the following week. I asked Ruth about the normal mechanism for referrals and why she thought it might have broken down.

> We make a notation on the chart and the chart goes through the well baby nurse. If a referral is necessary, then she contacts the district nurse and initiates the visit. The nurse would look at the chart and get the information on the clinic visit from there.

I asked her if she ever spoke directly to the district nurse concerned and she responded, "No - that isn't my understanding of the procedure. Perhaps I should if referrals don't get through." In the case of Mrs. Heston, who lived in the Central Clinic area:

> I would tend to leave this for the well baby nurse because the birth notice would be at Central, so would need to be transferred - so that would have to go through officially and we don't visit out of our area...within the clinic area I don't think there's a problem of territoriality. (8/2/80).

This conflicted with her colleague, Vira's, perception, she said, "I would like to follow-up on this lady I saw in clinic but it's in Lisa's area [another colleague] and she doesn't like cross-visiting. She's protective of her families." (26/1/80) This problem appeared to be localized to one nurse.

Time Constraints and Their Effects on Care

While Ruth was able to take additional time in Greenfield Clinic itself, she found herself more constrained in Richmond, the satellite clinic. There were only two nurses and on the afternoons I observed there it was busier than the main clinic. Another difficulty was that the population was transient, or the mother's booked on the day of the clinic so birth notices or clinic records were unavailable. While Ruth took a thorough history of the presenting problems, for example, feeding, she did not always have time to ascertain past history or social conditions. As this clinic served the area where a school survey showed 41% of the children came from single parent families, social conditions were frequently of concern.

One example of this lack of background data occurred in the case of Alexa Daniels and her five month old daughter, Tina. Alexa brought Tina to the clinic because of a severe rash in the diaper area. Ruth checked the duration of the rash, for changes in feeding, voiding patterns, her teething, and evaluated Alexa's current management. In light of her observation of the mother-daughter interaction she judged the mother to be functioning satisfactorily and to have a good relationship with Tina. What she did not know was that Alexa herself had been in fifteen foster homes, had difficulty relating to other adults and that Lois, the infant-preschool nurse, had visited her several times in the newborn period. Alexa had had difficulty deciding whether or not she would relinquish the baby and was now having difficulty with the family where she was currently living. Tina was immunized at this first visit (6/2/80). When the chart went back through clinic Lois decided to check with Alexa to see how the rash was clearing and found she had left Edmonton. The woman she had stayed with said Tina was in foster care, but this could not be verified through social service. Because of inadequate records Ruth did not have information at the clinic visit indicating that Alexa and Tina were categorized as "at risk".

Faisal Rajan was ten months old and his mother brought him in because he also had a diaper rash. The rash was ulcerated and covered the penis with a sore near the meatus. Ruth felt that mother should see the doctor "it doesn't look like a teething rash, nor like thrush" and "it could be internal with that sore on the opening there". Faisal had not yet cut a tooth, and Mrs. Rajan was concerned, it turned out she had not yet given Faisal junior foods or foods to chew, so Ruth suggested introducing mashed table foods. She showed Mrs. Rajan on the growth chart where he was underweight for his height and suggested a switch from 2% milk to homogenized to provide more calories. Faisal was a bright alert youngster and under the open neck of his blue suit I noticed a red and green plaited necklace, which some African groups use to ward off the evil eye. When Ruth left to get a feeding guide I discovered that Mrs. Rajan was from Tanzania, she had come with her husband and his parents to Canada two years ago and all lived in a one bedroom apartment. In the discussion session after the visit Ruth felt the mother to be interested in her son but ignorant of child development. She had not picked up the social background which might account for the lack of knowledge. Again the clinic was very busy and her focus had been on solving the presenting problems, this precluded some of the social chat that normally occurs and generally yields useful background information. This information is rarely charted however, so does not get passed from one nurse to the next. (6/2/80)

Group Education

The other activity which occurs in conjunction with the clinic is group teaching. Ruth is keen on teaching and taught kindergarten nutrition, Grade VI baby sitting, Early Bird prenatal classes and a group of student nurses while I was in clinic. She sees group teaching as different from a one-to-one situation.

> I've either come in response to the teacher asking me, or because it's a set programme - so the same sort of needs identification does not occur as in a one-to-one situation. The group thing tends to be more formal, lecture with discussion - less interaction between the group and myself than you get in the individual situation....I do try to get verbal participation in the group. I try to answer questions

> as well as provide information. With a group too, I may tend to use paper activities.

In the kindergarten class Ruth used a game she had invented and when she went to orientate student nurses to community health she had also produced a game that made the students think about common events that a nurse in the district might encounter. The game had situations between a nurse and client written on a game board with nursing intervention on cards. A dice was thrown and the players advanced to a square, the problem was matched to a solution held by one of the players. The game terminated when all players had disposed of the solutions she held in her hand. While the game was played Ruth circulated and answered questions about the problems on interventions. The game appeared to stimulate lively discussion in the groups.

When Ruth taught the Grade VI glass she utilized an educational outline prepared for this purpose. At times she seemed inhibited by this when her behaviour was compared with other classes she gave. She did provide ample opportunity for students to ask questions and answered them all respectfully, only setting limits when one or two boys seemed to be getting out of hand. If she felt a word had been used that the children might not understand she asked them to tell her what it meant, then clarified if they did not respond. Afterwards she commented:

> I like teaching these classes, but there are some children who just don't see the point - they babysit without a certificate, so why do they have to learn about it. You have to stress the examination at the end to get some of them to do any work. I suppose with guidelines the teacher could do this, but it gives me a chance to get to know the kids.

That such classes had a spin-off value was evident in Ruth's interaction with the girls at Helston School.

Early Bird classes gather couples in early pregancy and the groups are often as large as one hundred people. The reason for this is that the agency feels, "it cannot afford smaller classes." Most nurses, Ruth among them, do not like this as, "it is impersonal" and "often in the smaller classes the important questions for indivdiuals are answered at coffee break." Ruth would like to teach prenatal classes if a possible part-time job is eventually created. I asked her why she volunteered for these classes, which involved evenings, when she sometimes felt the combination of home and job to be demanding.

> I enjoy dong prenatal classes and I think probably it is related to my whole belief about the importance of teaching. I tend to be involved more in teaching altogether than most of the other nurses. I think it is one time when we can get involved in promotion of health as well as prevention. (18/2/80)

This statement supports Ruth's perspective that her priority in public health is education. Her actions show she believes in active involvement of the learner in her groups where feasible, but group size may be an inhibiting factor.

Summary

Ruth generally asked detailed questions in order to obtain information from the client. With time constraints the information gathered in the clinic appeared to focus more on the problem at hand rather than extending to a more general assessment of the family situation. Ruth demonstrated her ability to balance agency policies and guidelines against client needs in the immediate situation. Despite her concern that spending a prolonged period of time with a client puts pressure on her colleagues she did not terminate two prolonged interviews until she felt satisfied that the client's immediate needs had been met. She questioned the mothers and then supplied information she felt they needed to enable them to meet their baby's needs. She was particularly responsive to the mother's feelings and was concerned about the mental health of the client as well as the physical needs. Ruth dealt with a situation where the mother appeared to have been misinformed by a colleague without creating a feeling of conflict of advice. Poor recording of advice hampered her efforts to determine whether the client had been misinformed or had misunderstood advice. Ruth again demonstrated by her action that she believes it important to inform clients of what is occurring and also of potential problems as she explained the process of immunization and included traveller's themselves in an assessment of their needs.

For group education situations Ruth endeavoured to involve the learners, through encouragement of discussion and by involving them in games and simulated situations. The latter demonstrated a creative approach to teaching on Ruth's part. She also demonstrated an understanding of the developmental level of the younger learners.

Ruth's Perspective of Nursing

The three dimensions of perspective cited by Becker, Geer and Hughes (1968), will be utilized to discuss Ruth's view of nursing. These are individual's definitions of the situation, the action or activities the individual engages in as a result of their definition and the criteria of judgement used by the individual.

Definition of the Situation

Ruth believed that the major purpose of public health nursing was prevention of illness and through this promotion of health. Illness encompassed physical and emotional health and the social factors that could be a causative factor. Ruth believed that her goal as a public health nurse was to provide clients with information so they could make informed choices about their lifestyles and the direction they should take to prevent physical or emotional crisis from occurring. For Ruth prevention meant identifying an existing potential problem and taking steps to prevent is occurrence (anticipatory guidance), or identifying an existing specific problem, solving it and taking steps to prevent its reoccurrence. Client education was the prescription whereby the goal of illness/crisis prevention could be achieved, however she saw her actions as including case-finding, referral, guidance and counselling. Ruth's role was that of an informed professional who could provide information for the client which would prevent future problems occurring, Ruth described education as an integral part of the nurse's role which took place in both groups and in a one-to-one situation whenever counselling and guidance were needed. Ruth believed that the basis for teaching was assessment of client needs and that this was achieved by questioning the client. She viewed adults as coming with a basic fund of knowledge and her function was to assess the level and accuracy of that knowledge. Ruth saw mutual respect between the nurse and client as necessary for successful intervention, she had to respect the clients previous knowledge and the client had to see her as a informed resource person.

In her nursing Ruth saw herself as an organized person, well accepted by clients and this was reflected in her daily activities and relationships with people. In her own life she believed in the value of continuing education for continued growth. She stated that her beliefs about nursing were imbedded in her values of her educational programme, where prevention and client education had been stressed. Ruth was committed to her work although family demands created stress on occasions when she looked at her priorities.

Ruth's Nursing Activities

Ruth demonstrated her belief in the importance of mental health in her work with mothers with new babies. She always discussed their support system with them and examined ways in which they could organize support if she felt it to be lacking. This was an area stressed in agency guidelines for family asssessment. This is an example of anticipation and preventive action aimed toward the potential crisis which can occur if a mother becomes socially isolated with a new baby. In her work with school children Ruth identified pre-existing problems, such as children attending school without breakfast, and suggested remedies for the problem. Her kindergarten class on nutrition, on the other hand, was aimed at promotion, through understanding, of healthy eating habits. With mothers both at home and in the clinic she identified problems and then took steps to provide the clients with information which would increase their knowledge of the problem. Over the course of the study Ruth's perspective on the role of education was evident. When she engaged in prescribed activities such a visual screening or head combing, Ruth took the opportunity to include health teaching as a part of her actions.

In one-to-one situations Ruth engaged in a great deal of information giving activities with the client. She used verbal explanation and reinforced this with printed materials when they were available. Ruth believed group teaching to be valuable and engaged in teaching in both school and clinic settings. In her classes she demonstrated creativity, producing games to involve the learner. In group situations she seemed to obtain more active participation of the learners than in the one-to-one counselling situations. It was evident, however, that Ruth found an opportunity for teaching in most instances where she was interacting with clients.

In interactions with clients Ruth utilized both questioning and observation to gather information about the clients knowledge level and potential educational needs. With school children she utilized opportunities to gather data as she carried out screening activities. She used probe questions to clarify information she had obtained so she could more clearly delineate the problem. There were times, such as in the instance with the school child who expressed feelings of hostility, where Ruth took the information at its face value, rather than probing further to determine if the information had more meaning than was apparent on the surface. In clinic, where the client often came with an identified problem, Ruth allowed ample opportunity for clients to present their perspective before she intervened, and she showed herself to be an attentive listener. In this respect she fulfilled the goals of an educator of adults in that she did attempt to identify the needs and goals of the potential learner (Knowles, 1976).

Ruth demonstrated respect for her clients in several ways. For example she called the school children by name, and spoke to the babies. She also accepted the current level of competency of the adult and the exaggerated fear of a client over immunization without being judgemental. Ruth stated that she felt it was important to remember that each individual was different from the next and in the repetitious activity of head-combing she demonstrated that she did indeed see the differences in each child. That she was respected by the school children was evident in the rapport between Ruth and the girls in the junior high school.

The fact that Ruth had a mainly middle class district in which to work enhanced her approach to client education as most clients did start with a basic knowledge of the subject on which she could build. Also many of Ruth's clients were able to articulate their concerns. Because she did not have a busy district she was able to engage in classroom teaching in the schools. However, she did find the amount of paper work in some schools to be excessive and felt it intefered with some of the health teaching she would have liked to do.

Criteria of Judgment

In nurse-client visits Ruth's major criteria for evaluating the client's capabilities was his/her level of knowledge. Outside the clinic Ruth was concerned about the social situation but within the clinic her judgement focussed on the problem in hand. In mother-child situations Ruth looked at a mother's coping abilities, how she was managing personally with various areas of her life, the ease with which she handled the new baby, how she was able to organize her household tasks, and her comfort with her own level of skill.

In the school Ruth assessed the physical and emotional health of the children. Her judgement was respected by the medical officer, who was willing to arrange a referral for a child before checking him herself in response to Ruth's report on the situation. Ruth used many probe questions to clarify information before she arrived at conclusions about a given situation. Ruth did not jump to hasty conclusions and on one occasion, when she felt the principal of one school was attempting to get her to take sides on an issue, she decided the prudent action was to withdraw from the situation.

In clinic, while she was concerned about the work overload other nurses might have, she allowed sufficient time with clients to ensure that their needs were met. She anticipated future problems and discussed these with her clients. In this area of evaluation her use of knowledge of child development was obvious as it was also in her formal teaching in the schools.

In evaluating client situations Ruth used her observation of the clients as well as verbal information. She balanced the client's needs with agency policy, using her practical experience to weigh the value of the theory on which agency guidelines were based. Thus Ruth blended previous experience with current observations. Poor records and insufficient information at times hampered her judgement. Lack of facilities on occasion also meant that even when she assessed a child as needing help beyond that which she could provide, she was unable to act on her decision. Breakdowns in communication within the agency also resulted in her decisions not being implemented in the case of two mothers where she had felt that a home visit was desirable after she had seen them in clinic.

The elements that constituted Ruth's perspective of nursing were: (1) that the focus of public health nursing is the prevention of physical and emotional illness; (2) health promotion is a part of prevention; (3) that the means of accomplishing prevention is through client education; (4) education means providing the client with knowledge to make informed choices about his/her lifetstyle; (5) that for nursing intervention to be successful there must be mutual respect between the nurse and client; (6) that educational needs are assessed by questioning to determine the client's level of knowledge. Her nursing activities and the criteria she employs to judge the situation reflect these elements. In one-to-one teaching situations she establishes a baseline on the client's current level of knowledge through questioning and provides information to either clarify misconceptions or fill in perceived gaps in knowledge. In group situations Ruth utilized strategies which involved the learner to a much greater extent than in one-to-one situations, but her assessment of learner needs was more indirect. She rarely got a chance to evaluate the effect of her teaching due to the lack of continuity of contact between individual clients and the nurse, the feedback loop, critical in assessing the client's learning, was missing in this situation.

CHAPTER 7

KATE

Introduction

Kate is in her mid twenties and is married with no children. She is of medium height, slim and always gives the impression of being in a hurry. She generally wears slacks and either a tunic top or long sweater, and could be described as casually dressed, but she is always clean and tidy. When we got to Kate's district it was soon apparent that her dress was appropriate to her area. Kate had graduated from a three year hospital diploma programm, she then worked two years in a hospital, completed a two year post-R.N. baccalaureate programme and then chose to work as a public health nurse. She had been in the clinic for two years at the time this study commenced and had the least nursing experience amongst the four subjects.

Kate became a public health nurse, "because I really believe in it...I think a lot of our problems are because we don't focus on prevention." I asked what she meant by this and she replied, "we're kind of catching the problems after they have really happened." She added, "if you're catching people before they get into hospital that's where community health should catch them." For Kate the focus was on illness prevention rather than increasing the health potential of the individual. I asked her how she viewed health promotion and whether she saw it as different from prevention and she responded, "I think they are different...but I do not really know what the difference in emphasis would be...." It was evident that she did not differentiate between the two in her approach to practice.

Kate also said that she enjoyed the hours of a community health nurse.

> I found when I was working in the hospital I grew tired of it...I was sleeping, breathing (laughs) work all the time and I didn't enjoy it, and I feel unless I'm enjoying my work I'm not doing [a good job]. I was interested in community health, I just wanted to find out more about it, so I went to University to get my degree with that in mind.

Personal Characteristics

Kate saw herself as "active in just whatever is important to me". She felt that whatever she considered to be "a priority" was where she put her time and energy. For Kate "sports are very important and physical activity". She explained, "I spend a lot of time doing that." Kate was active in both women's broomball and soccer and would play in tournaments on the weekend. Music was also an important part of her life, "so I spend a certain part of each day doing that." Kate got up at 6:00 a.m. each morning to practice the piano before coming to work and also took regular music lessons. In her leisure activities she demonstrated a commitment to her interests and later I observed a similar commitment to her work. When Kate felt something was important it received her full attention and energy.

Kate also perceived herself to be "interested in self improvement and self development, so I don't stagnate." She was taking a University music course in her lunch hours. To do this she had to arrive at work early, so that she could leave early in time to reach University for the class. The drive to and from class took about twenty minutes, so the course demanded motivation on her part to even reach class. The reason she gave for attending was that she "enjoyed learning" and "liked to learn new things and keep on going". Being with Kate was an exhausting experience as she rushed from place to place in a district that was demanding of her time.

Kate thus saw herself as an active and energetic individual interested in sport and music outside her work. She was anxious to go on learning and was, "unwilling to settle for the old and familiar if it doesn't work anymore." She believed she gave her full energy to any project she undertook. As a nurse Kate feels she offers the client, "my knowledge and my education".

Public Health Nursing

For Kate the focus of public health nursing is, "prevention of illness". She believes her priority is "to meet the needs of the client... to see what is important to them." She further explained this by saying "I don't see my priorities as being the same with every client...they're different with each individual."

I asked Kate what she saw as common priorities amongst clients and she countered, "I would take that to mean needs that are more common from one client to another." After thinking about this Kate explained:

> The clients I have in my area right now, their priorities, are based on child-rearing, things like toilet-training, nutrition, "what do I feed my baby?", discipline. I see the needs of my clients as being...quite different from the priorities determined by the local board of health. For instance, immunization is not a priority [to mothers] in my area. They do end up getting their children immunized when you go and explain to them that they should...but it's not a priority in terms of what they see as most important. (29/9/79)

Kate reiterates this feeling frequently. In January she said:

> If I can make sure the children are fed, tension does not build up to the state where the kids are mistreated [then] I feel I am doing my job. If they do not get immunized now it is too bad...but we will catch them when they get to school. (24/1/80)

Kate looks at the agency goals and recognizes them as unrealistic for some families in her area. She sees her district as "low income housing, many single parents, economic problems, the families are very transient." She also has many families where English is a second lanaguage, so communication may be difficult. Many of her baby visits are to "very young mothers, 17, 18, 19 is common". "You go back to the same place three times in a year and the turnover is so great it's a different family [each time]".

She does have a small area, around the edge of her district, where "the homes are middle-class", but she does not often visit them. Kate feels that the majority of clients in her area, "are living from day to day" and that, "their needs are associated with the day-to-day existing things like feeding and living with their kids."

Kate, in contrast to Carol and Ruth, deals mainly with short-term goals for clients in her area. Maslow (1970) speaks of a hierarchy of needs. Physical needs, safety, love and affection, self-esteem and self-actualization constitute the levels of the hierarchy. He argues that each level of need must be met before the individual can attend to the tasks at the next level. For Kate nursing interventions focus on meeting client needs at the lowest level of Maslow's hierarchy, that of the physical needs. Sometimes she sees the clients reach the next level, where they are concerned with child safety, but she feels that generally the agency programs for safety, immunization, and child development are not of concern to these clients. This does not mean that Kate does not try to implement them. She speaks of the need to negotiate with clients.

> If I perceive something to be a need for the client and she does not, what I try and do is help them to see it and regard it as a priority too. I spend time, energy and interest on the things that are an important priority to me...so I hope they will too, so I try and make it important to them."

Kate recognizes the need to secure the client's interest if she is to motivate them to change their behaviour.

> If it's not important to them or I cannot instigate the change I have not made it a priority for them...so I am not meeting their needs. I want a change that is self-motivated...or else as soon as I'm gone the client will move right back to the original situation. (28/11/79)

Kate believes very strongly that she does not separate her personal values and beliefs from those she uses at work.

> I very much believe in good nutrition, I very much believe in exercise and I very much believe in health for myself...I use those beliefs all day in work...and also all day in my own life too. (28/11/79)

It was evident that Kate did carry through her beliefs, she ate cheese, salads and bran muffins for lunch and her active participation in sports was frequently mentioned when she was talking about her evening or weekend activities to her friends. Once she had finished her work for the day she forgot about work.

> As far as thinking about client 'x' - I don't take that home with me. It does not do any good for me and it does not do any good for the client...I need my leisure hours. (28/11/79)

One of the reasons Kate had left hospital nursing was because she felt she was never free of her job and she had felt this to be unacceptable. She wanted to enjoy her work, give it her full energy while she was doing it but then to turn to other things. She perceives herself as having achieved this.

Kate was not sure of her capabilities as a public health nurse. She had volunteered for the study, "hoping to learn something that will improve my nursing". She felt frustrated at times because, "I feel we're spread too thinly...I would like to do a better job but I cannot because of time restrictions."

She got satisfaction from some of her clients who provided feedback on the effects of her care. "People are well, they are not as vulnerable, [as patient's in hospital] they are able to tell you when you have done something for them". Also she got feedback from the people she worked with, "teachers, day-care workers...they appreciate what you're doing and let you know you are being helpful...and that contributes to job satisfaction...in the sense that I know I have helped."

She saw herself as relatively inexperienced and would have liked more guidance from the supervisor.

> It seems to me that an effective administrator is going to try and make her goals and the agency's goals congruent with her worker's goals. Then you are both working toward the same goal, but I have no idea what my superior's priorities are...I know my agencies' priorities but they are vague and abstract, they are not specific enough for the worker...I think the supervisor's job is to make them more explicit...so she knows what I am doing and I know what she expects of me. Because I do not have clear cut guidelines I am hoping that I am doing what I should be doing...but I am not certain. (28/11/79)

She explained that her ideas of what she should do were "piecemealed" from impressions given her by her colleagues. "I feel pretty confident I have got my priorities right...but I should not have to depend on getting it all by chance". Kate was upset with the line-staff relationships, but while she thought of asking for a transfer to another clinic, "I think that will not solve problems for new nurses here", so she was instrumental in organizing the group dynamics workshop mentioned in Chapter 4. So while Kate felt she lacked direction within the clinic, she identified sources of feedback that reassured her that she was doing what was expected of her as a nurse.

Summary

As Kate's perspective is presented it emerges as centering on the needs of the client. Kate's goal is to prevent illness and she believes that this is the focus of public health nursing. She saw her district as low-income with a transient population and this influenced her view of the clients who she perceived as needing help in meeting their needs for basic physical existence. She recognized the need to implement agency programmes, but based on her own approach to life, believed change will only occur in client behaviour if she can encourage them to view that change as a priority. At the same time she recognized that some families may have multiple problems and not progress beyond needs related to basic physical care of their children. To understand Kate's perspective it is now necessary to examine the context within which her nursing takes place.

Common Events in a Working Week

Kate's description of a working week focusses mainly on her schools, of which she has two, one large elementary school and one smaller elementary-junior high school. On a Monday morning Kate comes into clinic but "I rarely come into the clinic otherwise, I have coffee at home and I find that half-hour is useful to spend with my teachers." She gets to the school at 8:30 a.m., "unless you're there before school or at recess you do not see them [teachers] except individually, when you knock on the classroom doors." She feels having time with the teachers in the staff room allows them to come up to her and say, "I did not talk to you about so and so." At lunch hour many of them, "go off and do their own thing", so this is not a good time to spend at the school.

At school the first part of the morning is spent in clerical work and once the teachers know Kate is in the school they send referrals to her. Kate finds it difficult to describe, "it's so different everyday, depending on what I am doing." However, on reflection, she says:

> I sort of have a set pattern for my year. First of all my priority screening, then immunization, getting my records ready, then working on maturation classes for the Grade VI's and the Grade II's visions...so for a particular two or three weeks I focus my attenton on one thing, then when I've finished go on to the next.

In the afternoon Kate's work varies from clinic to home visits, "Usually I am in clinic once or twice a week". Because the satellite clinic, Richmond, is in her area, "I usually spend Wednesday afternoon there, that way I get to see a lot of Mums. In this area where there are so many problems I think that's important." Kate did not speak much about her home visits except to say "I have a lot, many of them 'at risk', young Mums, unmarried, that sort of thing." After a pause she added "Oh, and I forgot the meetings, Tuesday is always district meeting in clinic and I'm on a few committees and things, like the mental health package thing." Kate did not mention prenatal classes, although she was teaching a series within the next few weeks.

It was difficult to timetable Kate's work because her plans changed from day to day as she adjusted her priorities. After a week of

Table 7-1

Activities in Kate's Work Week Recorded by the Observer
for the Periods 12-16 November, 1979 and
18 January-2 February, 1980

12 - 16 November, 1979

Days of the Week	Hours of the Day 8:30	9	10	11	12	1	2	3	4:30	Evening
Monday	Public Holiday				-		Clinics Closed			
Tuesday	District meeting				Lunch		School A/Records			
Wednesday	School A/Home Visit/School/Lunch						Richmond Clinic			
Thursday	Genetics Inservice				Lunch		School A/Records Home Visit			
Friday	School B/Vision Screening/Lunch						School A/Immunization			

28 January - 1 February, 1980

Days of the Week	Hours of the Day 8:30	9	10	11	12	1	2	3	4:30	Evening
Monday	Off-Cumulative time				Lunch		Home Visits/School			
Tuesday	District Meeting				Lunch		Clinic	Phone Calls		
Wednesday	Richmond Clinic				Lunch		School B/Immunization			
Thursday	District Meeting			Preview Pre-Natal* Films			School B/Records			
Friday	Schools A&B				Lunch		Clinic/T.B. Reports, etc.			

* Lunch eaten in transit between clinic and school.

observing Kate I generally felt totally disorganized, yet she seemed to get her work completed.

In looking at two weeks of work for Kate it becomes obvious why schools dominate her thinking when she describes her week's work (Table 7.1). Because her district is fifteen minutes drive from the clinic Kate also tends to use one of her schools, Snowden, as her headquarters. She calls into clinic from there to see if she has any messages from clients or referrals to which she needs to attend. If she is immunizing she will go to clinic in the morning, on her way to school to collect vaccine, otherwise she only goes in for meetings or if she needs records. One can see why Kate also feels "bogged down by paperwork". It so happened that in the two weeks recorded here she was preparing for immunization at both her schools, Snowden in November and St. Anthony's in February, but in the other two weeks I was with her, she also spent at least one half of her time in school on records. Kate used to go to her school, then go out on a home visit. She explained this to me, "You cannot go too early - the Mum probably won't be up - she will be back in bed after the early feeding". As with the other nurses, two half days of each week were occupied by meetings, so in the holiday week only three work days were used for client care, and even then paperwork occupied a large part of the remaining time. As Snowden was a large elementary school with over 400 students, Kate did rely on the teachers to keep her informed of potential problems. Kate spent time with the teachers, at the beginning of the year, she went to staff meetings and told them what to look for and how to report back to her. Kate felt that because she used one school in place of the clinic as a social centre, she was highly visible to the teachers and this may have resulted in her being well utilized. She also said, "I like my work in the schools best of all."

One frustration for Kate was to fit everything into her week. She felt a lot of time was wasted in social activities at the clinic because "while I think it's important that everybody gets together and meets regularly I think coffee breaks often get extended." This was another reason she did not call in to clinic each morning. I asked her whether she planned her week and if she did how closely she felt she stuck to her plan.

> Well, it changes, like I'm always getting telephone referrals from social service [at the hospitals], and if they call and want me to go out and see a Mum and I am slated to be in my school I go. I do have definite days to be in my schools, I always go to Snowden on Thursdays, and I'm always going to be in St. Anthony's on Mondays. While they know my schedule they also know things may come up, then I will give them a phone call and tell them.

The two weeks I was recording Kate's activities she did not work on the Monday and had meetings on the Thursday morning, so her planned schedule was not carried through.

> This morning I had a call from [the social worker] and she remarked that lately she has been contacting me regularly for referrals. She said 'You know you have all the Mums with the problems out there'. She thinks it's the housing. (22/2/80)

Kate went on to say she thought Hazel, who had the neighbouring area, had a lot of referrals too, whereas Jean did not have many problems, but she had an area with an older population and few young Mums on welfare.

> My area is hog wild right now...I don't know whether that's because we've been away for the workshop...but this past week, it seems I have done nothing but home visits...but I'm not going to be spending the afternoon doing vision screening at Snowden when I've just gotten two referrals from social services saying "these Mums have just been discharged and can you go out before the birth notice arrives."

Kate's District

Kate described her district as being mainly low cost housing, which is government subsidized.

> The priorities for admission into the units is given to those with low incomes, so I seem to get a lot of multi-problem families. I have a lot more single parents than most nurses do. Last time one of the schools in my area counted there were 41% single parents - that includes widowed, divorced as well as never married.

As she drove me around her area it seemed to be row after row of grey concrete houses. On the periphery of her area were some single dwellings with gardens that appeared to be well kept. The whole area Kate serves is about twenty blocks long by ten blocks wide, but her population is as high as nurses with much larger areas. Parking is a problem and Kate either had to park on the perimeter road and walk into the houses or else she had to put her car into a parking space and hope the owner was not home. There was a Day-Care in the middle of the housing complex. It too was built of the same grey concrete, which was cracking and peeling away from the windows. Children from the houses were playing in the parking area and on the grass when we went in October, some of them were too small to be aware of cars, but they appeared to be unsupervised. Kate said:

> Some of the children in the Day Care should be in kindergarten, but they will only take children full-time because of the subsidy. Many of those children have single Mums, so they have to work, and the children have to be cared for for the whole day.

Home Visits

Contacting a Family

In early October Kate was asked by a teacher at Snowden School to check on two children who had been absent from school. As we drove over to the map of the housing complex, to locate the site of the house, Kate explained.

> The teacher reported that the little girl has been absent and she had heard it might be mumps. Also the boy was placed in Grade I and he needs to be put back into kindergarten but they must ask the parents. The family do not have a telephone, so they wanted me to make a home visit. I have to be careful that I am not used for truancy checks, but I need a health record from Mum too. (11/10/79)

The first day we called the house appeared to be deserted, so Kate telephoned the manager of the complex to ask if the Mirandar's had moved from unit 456. She said:

> You have to know the managers otherwise you would lose track of these families altogether. Most of them are helpful if they know you are the public health nurse. (12/10/79)

The following day, we called at the housing office and found that the Mirandar's were still in residence. (13/10/79) Kate said, "The little boy showed at school yesterday with a note saying he was sick, but he was absent again today." The manager said that the family were being hounded by bill collectors and that the caretaker (who lived down the block) said the children were locked out in the daytime. The family owed two months rent and would be evicted if they did not pay soon. We went round to the house but there was no reply. Kate left the questionnaire and consent form in the mail box. "Perhaps if she was in and gets that she will know I am not a bill collector."

By 17/10/79 the children were still not in school, but the manager of the complex told Kate she would give her some information if she called round. Kate found out Mrs. Mirandar's place of employment, she worked as a cocktail waitress, and finally managed to contact her at work. The children had had whooping cough and Mrs. Mirandar seemed quite relieved that the teachers wanted to put the son into kindergarten. She arranged to meet Kate at the school the next week. Both parents came and Kate reported she had a productive meeting, the childrens' health problems were discussed and immunization consents signed. Mrs. Mirandar saw the teacher. The family had moved to Alberta from the Maritimes and both parents now had jobs, so the manager of the housing complex was giving them time to pay the back rent. Kate felt this family was representative of the problem families in her area, and were not atypical when one considers the difficulty she had establishing contact with them.

Nurse-Client Conflict of Interest

Kate was asked by a teacher at Snowden to visit Mrs. Hudson. She had several children in the school but Duane, the child in kindergarten was not only dirty, according to the teacher, he smelled. Kate had mixed feelings about going on the visit. She had checked all the children and they did appear to be unwashed and unkempt. She had never met Mrs. Hudson before this visit. She said "I don't feel good about going to someone's house to tell them 'your children are dirty, wash them!' yet, "the teachers were all complaining so I felt it was kind of urgent."

Kate was obviously uncomfortable as she spoke of the visit. "I always feel I am stepping out of my territory in the mother's eyes".

Because of her discomfort, "I gave the Mum the impression I routinely go and visit the Mum's...and it's partly true because if mothers can not be contacted by 'phone, I do go and visit." In Kate's district, because of its compact nature, distance is not a problem, she is in the area anyway and "dropping in" is an accepted practice. "As I go around I'll call at a door that is open - a kid will answer and say 'Mum's having coffee next door.'" Kate explained she might go next door or wait for the Mother, but that in her area you call on your neighbours when you feel like it, "so it's accepted if I just drop in too." This has been reinforced by her experience in the area.

Mrs. Hudson, when the topic of cleanliness was brought up, said that the children were spotless when they left home and suggested they got dirty on the way to school.

> I know in fact that this is not true because the teacher told me that the children were wearing the same clothes everyday and I made a point of going and looking at the children every day for five days - and one child was wearing the same little shirt each day and it got dirtier and dirtier.

> Kate did not confront the mother with her observation.

> I felt inadequate anyway, like how effective am I being with the visit. I wasn't sure what I wanted to accomplish before I went to see her. In combination with the mother's not levelling I found it most frustrating. (29/9/79)

Kate reported a few days later that the teachers had told her the children were clean now and I asked her if she felt better. She replied "Not really, all the Mum knows is the nurse from the school came and she doesn't think that my children are very clean. That still frustrates me."

During an interview with Kate (28/11/79) I asked her again about this family, as she spoke, the cause of her frustration became clearer.

> I was meeting my needs...and the teacher's needs...and perhaps the child's needs in that the kids are clean now and not offensive to the

> teacher...but I didn't meet the Mum's needs. The childrens' hygiene was not important to that mother. I did not make it important to her, so as far as I am concerned I did not meet her needs - that's why I am doing this job. The child was being treated differently because he "lacked hygiene" so for me to act was a need of his - so I go stomping off to the house - but what I would have liked to have done is make it a need of the mother's.

Kate knew the mother did not really internalize the need to see the children were clean, for while the children had been clean since Kate's visit, when the mother came for a parent teacher interview the mother told the teacher the school nurse had been and then said, "the nurse does not seem to realize that he gets dirty on the way to school."

> So my visit was effective in that the child came to school clean... but the mother is only sending the child that way because the nurse went out and she was upset about having her parenting skills questioned, I guess. It wasn't an effective change...it's not the kind of change I want to bring about...I want a change that is self-motivated. (28/11/79)

From Kate's point of view this mother was coerced into sending her child to school clean. That violated her notion that for change to be effective it must be perceived as important by the client. "My need is to have the client's needs met - but I didn't make the child's hygiene a need of this mother." While Kate achieved her objective in terms of the teacher and child interaction she achieved it in a way that was in conflict with her belief about nursing.

Another reason for her frustation in this situation may be related to Kate's perspective on respect.

> I think in nursing you have to be honest with someone and that I think, shows respect for them. I respect my clients and I hope they would respect me because if they aren't totally honest I can't do my job effectively and honesty is part of respect. (28/11/79)

Here the client was not honest with Kate, but nor was she totally honest with the client. She found herself in a situation in which she violated her own values. "Respect is something you are going to create for yourself...unless you give someone a reason to disrespect you."

Helping the Client with Basic Care

Kate had said that many of her client's needs and priorities were related to "things like nutrition - what do I feed my baby?, toilet training, teething - everyday child-rearing things." She also said many of her mothers were young and unmarried. Louisa Lubbertz, who was seen by Ruth in clinic when her daughter Ebony was two weeks old (Cf. Chapter 6), was representative of this group of mothers. She had dropped out of school at sixteen, her parents were separated and after leaving school she kept house for her father and looked after her younger sister. Now she was staying with her mother, who was on welfare, and who attended A.V.C. for a work upgrading programme. They lived in a small three bedroom townhouse, the occupants being Louisa and Ebony, her mother, her sixteen year old brother, another brother who was in junior high school and her sister who was in Grade I. The visit Kate was to make was a regular new-born home visit. She did not know Ruth had seen Louisa in clinic, because the message had not reached her - this was a Wednesday and Louisa had been to clinic on the Friday. As we went toward the house I indicated that I might have met Louisa the previous week in clinic. There was no telephone number listed on the birth notice, or in the telephone book, so the visit was made unannounced. Kate said, "I prefer to arrive without the Mum knowing I am coming - that way I can assess what is really going on."

When Kate knocked on the door there was a pause before it was answered. Louisa opened the door, she was wearing a thick pink housecoat and had obviously been vacuuming. A young man was sitting on the chesterfield and Ebony was asleep in her carry cot, which was on top of a dresser behind the T.V., which was turned on. Kate said "I am Kate Flemming, the public health nurse in this district and this is Peggy Anne Field, a nurse-researcher who is with me this week. Is this a convenient time or would you rather I came back next week?" I asked Louisa if she remembered my taping her visit to clinic and asked permission to record this session. Kate in the meantime had walked over to see the baby.

Kate: I hear you were in clinic last week.

Louisa: Yes, Friday.

Kate: Did you have a problem?

Louisa: Yes, she was eating so much and getting upset - I am taking her to the doctor tomorrow. She's doing better now, she drinks a bottle in the morning - then again at ten and two and she slept six hours last night.

Kate: Was her weight normal when you brought her into clinic?

Louisa: Yes, it was okay.

Kate: Usually babies take what they need - if they need more milk they take it.

Louisa: She's having Pablum.

Kate: Are you giving that after the milk rather than before? Because it's more important right now that they are getting their milk rather than getting Pablum.

Kate then asked Louisa who her doctor was and what time she had an appointment. She then returned to the topic of the feedings.

Kate: The feedings are every four hours?

Louisa: They are lengthening out.

Kate: Does she sleep through the night at all?

Louisa: More or less...she will wake up at three or four or five o'clock in the morning...usually when she wakes up she will be just a little hungry...or she wants to be changed and she will go right back to sleep.

Kate: Was there any other reason you are taking her to the doctor, other than the amount of milk?

Louisa: He just wants to see how she is doing more or less.

Kate went on to check whether Louisa was feeding any extra water, as the townhouse was warm. "It may be that she gets thirsty rather than hungry." Louisa responded, "That's what I think but my Mum thinks she's always hungry." Kate then pursued the topic of mother's involvement and at this point discovered that Louisa was living with her mother.

Kate: Oh! really! This is your mother's house?

Louisa: Yeah.

Kate: (to boy) Are you related?

Boy: Brother

Kate: I see! (to Louisa) How about you? How are you feeling?

Louisa: Not bad. I just feel tired. My appetite's pretty low. I don't feel like eating.

Kate: That disappears after a while...but it is important that you keep your diet up to get your body back in shape, you need fruits and vegetables, protein and iron...especially iron...that will get your blood back in shape.

Louisa said that all she had to eat all day was a hamburger, Kate acknowledged it is hard to eat if you are not hungry, "but maybe if you take time to prepare some of your favorite foods...."

Kate then returned to the baby's feeding:

> I would not be too concerned about the amount of milk that she is taking...if the baby was taking too much milk, or the weight was above normal, the nurse would have told you at clinic when you brought the baby in...as she checked the weight. I am sure she would have told you otherwise. Is it Similac you are using? The powdered kind? (Louisa nods)...and you are mixing it properly? (Louisa nods).

Kate did not ask the mother what advice the nurse in clinic had given her, so she did not discover that Louisa had been advised to try to decrease Ebony's milk intake. Her history taking tended to jump from subject to subject, returning to the main problem in between. She also tended to make assumptions about the situation, here she assumed, from her experience in the area, that Louisa was renting the house, then found out that she was living with her mother. Following this exchange Kate asked if Louisa had been attending school and she responded that she will be taking correspondence courses in January. Then Kate again returned to talking about the baby.

> Kate: Your baby does not look overweight or anything to make one concerned about the extra feedings...she looks nice and healthy. What's her name?
>
> Louisa: Ebony Jane.

As Louisa had already visited the clinic Kate only asked one question about the pregnancy, "Was your labour normal?" then went on to explain to Louisa about Richmond Clinic - Louisa had been to Greenfield on her initial visit. She gave directions on finding the clinic, which was upstairs in the shopping centre, then said:

> Maybe I can write it down for you so you can telephone and make an appointment. Ebony was born...23rd...that would be December 23rd... so maybe the first Wednesday after Christmas...you'll notice the phone number is the same for Greenfield and Richmond Clinic...but when you phone just make sure you tell them you'd like to come to Richmond.

Kate checked on transportation and found Louisa could use the family car. For the first time in the visit Louisa raised a question, "Is it all right for me to give her a tub bath now?"

> Kate: Yes, now the cord is off. Why they didn't want you to do it before was because of the cord. Once it's completely dried and there's no problem with it that's fine. Have you given her a bath yet?
>
> Louisa: (Nods).
>
> Kate: Did you feel okay about doing it - or a little bit queasy the first time?

Louisa: Um...a little bit queasy.

Kate: You would probably feel better about doing it in the evening when your Mum is here...

Louisa: Ummh...she gets every Friday off...and that's the only time she gets off...so..../

Kate: Well, you talk to her about it...but please feel free to give me a call if you want. I am in the area, so it is no problem to help you out if you want.

In talking of this after the visit Kate said, "I want them [clients] to feel I am available but don't want to make them dependent on my help." In evaluating the family Kate said:

> I think the most important thing about the visit was the mother's concern about feeding. She seemed to be worried she was overfeeding the baby but she [Ebony] seemed content. There seemed no indication of overfeeding. The clinic does not recommend Pablum until three months...but when the mother has started it on her own I don't like to make her feel guilty by saying it's not a good idea. (13/11/79)

Kate shows that she is able to balance clinic guidelines against individual needs of the client. The visit demonstrated the effects of lack of continuity of care for clients, where Ruth was concerned about the possibility of overfeeding and Kate, not realizing the earlier situation so unable to assess if it had changed, gave the mother conflicting information.

> The brother being there made me uncomfortable. I would have liked to ask some more questions, about the father for example. I also did not say anything about birth control...and I don't know if I need to at this point.

Kate seemed to be uncomfortable in the presence of a third person. During the study she was the only nurse to be concerned about the tape recorder and in several early visits made comments about the client's reaction, "She seemed reluctant to answer...I wonder if it was the tape." She also mentioned, "I was uncomfortable asking her about birth control with the tape on."

The Dilemma of Respecting Individual Rights

Kate telephoned Louisa several times to check on her progress but she did not appear for Ebony's immunization so Kate was asked to follow this up. All families whose birth notices were at Greenfield clinic were classified as defaulters if they had not appeared for immunization by the time the baby was four months old, Louisa fell into this group. Kate reported:

> I spent all day on the phone trying to find out where the baby is... Mom said Louisa wasn't living with her anymore...I had to visit the house several times to find this out. No one answers the phone... finally mom was there and gave me Louisa's phone number. She said the baby was with...she didn't say apprehended...she said welfare had the baby. So I phoned Central's Regional Office and the South Office trying to find out where the baby is, and they didn't have anything at all, so they suggested I call the unwed mother's unit to see if maybe she actually gave the baby away for adoption and they didn't have any documents on the list. So I've tried to phone Louisa several times, she works at 2:00 p.m. and there is some fellow that always answers the phone, I know she's there because I phone at different times, but he doesn't put her on, obviously they don't want to speak to me. He knows I'm the public health nurse...I don't have the address, Mom didn't want to give me more information than that and I didn't want to push her for it...so I don't know what's happened, I have no idea. I'm going to leave it for awhile and try again later. Things may have changed

Kate was reluctant to push Louisa's mother to get more information, yet she was concerned about Ebony's welfare. She suffers a dilemma between her need for information and he feeling that she should respect the rights of individuals to withhold information if they wish to guard their privacy. It appears that when clients do not volunteer information freely she suffers discomfort at probing into people's lives, even when the information may benefit one of her clients.

Gaining an Entrance

In Kate's area it was difficult to get hold of mothers before a visit and Kate herself had a preference for arriving unannounced.

> Often I'll go to one of the places in Richmond Acres and I'll knock on the door and I won't get an answer. I'll hear babies and children screaming in the back...I'll knock on the door again and if I still don't get an answer I'll open the door and say "Anybody home...?" Often Mum's upstairs, busy with the baby and I just call out, "it's the public health nurse, are you busy?" and what they say back determines whether or not I say, "Well, I'll come back another time", or whether I go in.

One afternoon we went to call on Mrs. Trevor, Kate went to the door and knocked. When there was no reply she tried the door and it opened. The noise inside indicated the family were home. She then called out, "It's Mrs. Flemming, the public health nurse". Mrs. Trevor answered the door and said, "My husband's leaving to go up north, he has a few friends in." Kate immediately said, "Oh, I will come back another time - what time is best for you?" Mrs. Trevor said, "I am usually in around lunchtime as the older kids come in from school." Mrs. Trevor did have a telephone but the number had been busy when we called. When the baby had been in to clinic his weight gain was low and he looked underfed, a neighbour had also spoken to Kate and said the baby seemed to cry a lot, so Kate wanted to check out the home situation. (17/10/79) Talking about her area she added:

> [In Richmond Acres clients] are used to people coming back and forth...the doors are left open...often the children are left alone...if I say "Hello, anyone home?" some little toddler might come up...then I'll stay until Mom comes back and talk about leaving the child alone.

Assessing the Situation

She feels that unannounced visits allow her to assess the situation more accurately:

> Moms change a lot of thing when they know I'm coming. The place is neat and clean, the boyfriend's clothes may be put away, the children are home...things are just too perfect to be real for that area...I'd rather be there when the problems are there rather than get a distorted viewpoint of the way it really is.

Kate explains that when she was new in the district she always telephoned in advance, "but it made such a drastic difference - I found out I was being fooled." Kate felt the clients deceived her because they were afraid that if she knew they were living with someone she would not approve, so "the clothes were gone and the boots were gone". If she just shows up, "I see she is living with a fellow, I don't mention it [to her] but to me that's another resource for them...they are not alone with that baby...so I don't see it as being a bad thing." On exploring further I discovered Kate felt clients tried to hide this information, for "if social welfare got to know then they are in big trouble." Here again one finds a conflict of interest among the helping professions, the nurse sees the mother as receiving emotional support, the social worker is concerned about the possible misuse of welfare funds.

The Information Gap

Kate sees nursing etiquette with the middle class family who comes from "the better houses in my area", as being different from that of the families from Greenfield Acres.

> I just wouldn't open the door. I wait until they come and I don't really know why. I guess it's because I think that the type of people who live in that house would not expect to yell "Who is it? Come on in!" While that is typical of Greenfield Gardens and Richmond Acres.

During my observations with Kate we only went on two visits to her "middle class residences". The first visit was the result of a request from home-care services to find out whether an elderly gentleman, recently discharged from a city hospital, was coping or whether he needed home care. Because of inadequate information obtained prior to discharge no telephone number was available, just an address. When we located the house it was obviously a better built and more expensive house than we had seen in the housing estates. The yard was cared for, the paint was in good repair, and there were lace curtains under the drapes covering the front windows. Kate was somewhat anxious, "I wish I knew more about the situation - I am not sure at all what is going on or why home care want an assessment." Kate had received the message second hand and the information given her by the nurse who took the message was inadequate. Kate walked up to the door, rang the bell and waited, after a pause a middle-aged woman came to the door and Kate asked whether Mr. Tkachyk lived there. "He's my father and he is staying here." Kate explained she had been asked to visit by the hospital but she had not received much information on the situation.

Kate:	How is your father?
Daughter:	He seems all right. He is getting some lunch.
Kate:	How long has he been home?
Daughter:	Oh, a few days.
Kate:	Was he in for surgery?

Daughter: No...he was out doing what he should not do...and he ended in hospital.

This comment brought the conversation to a halt. After a pause Kate asked if Mr. Tkachyk lived with her, and his daughter replied, "As long as he behaves himself." Mr. Tkachyk himself appeared at this point, he was about 5'6" tall and he was dressed in a blue dressing gown, on his white hair was perched a round Rumanian hat. He spoke to his daughter in his mother tongue and he disappeared back to the kitchen. It became obvious we would get no further information on the situation, so Kate asked if she could have the telephone number. Although Kate said, "As I do not know your name I could not look up the number in the phone book, could you give it to me so I can call to see how things are going?", the daughter did not mention her name but only supplied the number.

After the visit Kate said:

> I felt handicapped by my lack of knowledge of the whole situation, why he was in hospital and what home care wanted evaluated. I find it so frustrating! You get these vague referrals from the social worker and just don't know what's what. Do you think she was suggesting he had a drinking problem...those vague hints "doing what he shouldn't"...it could be...but I felt she was hostile to my visit.

While Kate was invited into the house, she did not feel welcome. She wondered, "did I come at the wrong time?" and then, "would it have been different if I had telephoned first?" For Kate it was a frustrating visit because of the lack of information she received on the purpose of the referral, which made it difficult for her to gain entrance to explore the situation.

Preventive Intervention

When we were driving around the estate looking for the correct row of houses we saw three young boys climbing on a piece of heavy equipment, which was on a flatbed trailer by the side of the road. Kate stopped the car, got out and went over to speak to the boys.

Kate: I wouldn't play on that if I were you boys - it could be dangerous.

Boy: Nah - I won't get hurt.

Kate: I'm asking you to get down before you do. It is a long way to fall if you slip. Also it is not your property, so if you damaged anything you could be in big trouble.

The boys grumbled but got off the trailer and walked away shuffling their feet. We drove back that way after making the home visit to Louisa Lubbertz and they had not returned. Many people would have driven past and ignored the situation but Kate was genuinely concerned for their safety. "So often their moms work and there is no one to check on what they do - if they moved a lever and the trailer shifted they could get hurt." This action is compatible with her belief in the need for prevention of hospital admission through community intervention.

Concern for the Individual

One morning she told me that she had to meet an interpreter at 1:00 p.m. so she could visit the Chu family, a sponsored refugee family from Vietnam. When stool specimens were collected from the family on their arrival in Canada one member of the household had had intestinal parasites and the purpose of the vist was to try to get a second specimen. When Kate had called earlier in the week.

> Only a young woman was home and she did not speak English - I was so afraid I had frightened her, she seemed to be scared. I tried to say "don't worry" and to tell her I was the nurse, but I am concerned I scared her. So I have arranged for the interpreter to come...I can get a health history too.

Promptly at 1:00 p.m. the interpreter met Kate. As he was able to explain my presence to the family I went with them. We were welcomed into a row house in Richmond Acres. A picture of the five families who were the sponsors for the refugees hung on the living room wall. All the family assembled, there were two men in their early twenties, two young women, a girl of five and a two year old, after a few minutes they were joined by an elderly woman, the grandmother of the children. When the family was finally sorted out we found there were two brothers and a sister (the mother of the two year old) and one of the boy's wives (the mother of the four year old). It turned out it was the two year old that had parasites. The two young men had been learning English and were pleased to show off their new skills, and the sister knew a few words that she tried out. The older of the young men served us coffee, while Kate did not normally take coffee she recognized the significance of the act to this family and drank it. The impression in the house was one of happiness. Both the young men had employment in a hamburger joint.

> Mr. Chu: It is hard - we have three bus - long time - but we work both - we work night - in day we go to school.
>
> Kate: You are learning English quickly - you know more than the last time I saw you.

Through the interpreter Kate got a health history. She enquired if the family had their Alberta Health cards and they showed them to her. She then enquired if they had a doctor yet. The interpreter knew of a doctor who spoke Vietnamese, but he lived on the opposite side of the city. He telephoned the doctor who, after the interpreter explained the situation, said he would make a house call if he was needed. So the family took the telephone number. The purpose of the clinic was explained and the nurse suggested the four year old might benefit from a dental hygiene visit. The two year old girl had decayed teeth and the parents were advised to ask their sponsors about dental treatment.

When we left the family asked Kate to come again and the four year old waved and said, "Bye, bye. See you." Kate laughed and said, "She's learning English too". Her mother responded, "She like to try". We had discovered that this family had spent nearly a year in a refugee camp in Hong Kong before being accepted by Canada.

> They are all so cheerful - you feel good about visiting them. They are trying so hard - and you look at other families in my district and wonder if they could not do better too.

In this situation Kate was concerned that her initial visit might have frightened the family. She arranged for the interpreter to come, and having secured his services she asked him to explain to the family who she was and why she was there, she also anticipated some future problems, such as the need for a doctor for the children, and organized resources for the family. She was also aware their providing her with coffee could constitute a significant social act for this family so drank it rather than causing offence. She was still concerned about the younger child's dental cavities following the visit:

> The last time we heard sponsored refugees were not eligible for dental assitance, but I must check to see if there has been a change - the little girl looked as if she needed urgent care of those baby teeth.
> I wish we could have stayed longer - they wanted us to, but I am so busy right now, perhaps I can call if I am in the area again. I'm sure they will recognize me now.

Kate wrote the question regarding dental care in her black book, she uses this to remind her of the things she wants to follow-up, "If I don't write it down it won't get done."

The Flexible Schedule

Kate had said that her priority was mothers in crisis. One morning she was scheduled to go to Snowden school to do her Grade IV vision tests. She had first called in at clinic and was making a phone call to a lady whose child had been exposed to a case of infectious encephalitis. This was a referral of a notifiable disease and all known contacts of the patient had to be traced and asked to go to their physicians for nose and throat swabs. As she was finishing reassuring the client the supervisor came in, "Are you busy this morning Kate?"

Kate: I was going to my school.

Norma: I just got this call from this mother - she seems very distressed - she has twin boys and they have diarrhoea and colic - can you go, it is in your district, or shall I find someone else?

Kate: No, I'll go - I was only going to do vision screening.

This house was in Kate's "middle class residence" area and was set in a crescent opposite Snowden school. We arrived, rang the doorbell and were greeted by a lady who had obviously been in tears not long before we got to the house. Mrs. Warren still had on her housecoat and had been lying on the chesterfield, a three year old girl was with her, she was dressed but had her shirt on inside out.

It soon became apparent that Mrs. Warren was at her wits end with the twins. She had tried everything for their colic and they still screamed all evening. She had tried changing the nipples and the formula, and now they had large, loose stools. She had a list of their feedings and stools to show us "I have to keep this so I know what's happening to each of them". In contrast to most mother's in Kate's area Mrs. Warren was in her early thirties, her husband was helpful when he was home, but he ran his own business and worked long hours. Mrs. Warren's mother came daily to take the daughter out, she commented, "Poor soul, she had to dress herself today...she is very good and fetches and carries for the boys."

Kate went in to check the twins, Brent and Bradley, and found no signs of dehydration or fever, so decided there was no evidence of infection. When Mrs. Warren had tried to call her doctor the office nurse had made her feel, "I was making a fuss about nothing." Kate reassured her that she would feel distressed with two babies," with diarrhoea they can lose fluid quickly - but I have looked at them and they show no sign of dehydration". She suggested giving Brent, who was stll having loose stools, apple juice for the day. Then starting half strength formula at bedtime. Mrs. Warren said she would try this. She offered us coffee at this point, but we declined.

As Kate listened to Mrs. Warren you could see a change occurring. When we arrived she was tense, her face was colourless and her whole attitude showed the strain she was under. Gradually her muscles relaxed, the colour returned to her face and the strain receded. The visit lasted an hour and a half, but Kate said, "I felt it essential to stay that long, to me it was time well spent". She told Mrs. Warren to call her anytime and that afternoon the mother called because Brent was not settling on apple juice, so she wanted to try half-strength formula. Kate told her to go ahead. The next morning Kate dropped in on her way to

Snowdon, Mrs. Warren was still anxious and Kate encouraged her to make an appointment with her pediatrician, which she did, to get his assessment of the colic. Kate also arranged for a nursing student (B.Sc.N.) to follow Mrs. Warren. Kate explained, "Mrs. Warren really knows what to do but I think she needs some continued support, the student can learn from her while she gets the needed contact from the student."

While the whole week was hectic for Kate she felt Mrs. Warren's needs were a priority so she did not rush the visit, this was not always possible as Kate pointed out.

> It is difficult to plan - when you go on a baby follow-up visit you don't know how much time you need. Sometimes I allow an hour and find I have to cut the mother off, when we are really getting somewhere, because I have to be back in clinic or I am helping immunize in a school. Often I will miss my lunch...I don't mind that...but you have these fixed obligations and those you can't change. (14/2/80)

The Unwanted District

That Kate's area was seen by other nurses as being multi-problem and a difficult area to work in was evident from a comment she made during my final interview with her.

> They told me when I first started that my area was the sort of area that when a nurse left, the nurse from this area would transfer over, and the new nurse would get this district. It was like that for a long time, they had five or six nurses, and constant changeovers. I stuck it because I liked the idea of getting to know my area...I found it challenging...but in a way frustrating too. Sometimes I think "Gee it would be nice to get rid of some of these visits and follow-ups and spend time in my schools doing education", but I like it being really busy.

Kate, for all the problems, likes the district. It is a reflection on the system that what is seen as a complex district is assigned to a brand new public health nurse. It becomes clear why Kate is at times concerned when she feels that administration is not really aware of what she does and one can understand her concern as to whether the goals she has identified as realistic in her district are compatible with agency goals.

Summary

Kate has a district in which the majority of clients live in high density, low income housing. Many of the families have only one parent in the home, most commonly the mother, and many of these are on social welfare. Because she has many young single mothers, the newborn visit is a priority and generally families need continued follow-up, this makes her home visiting heavy. Frequently she has trouble contacting families or loses track of them due to high mobility. Her schedule had to be flexible to accommodate the needs of clients in her area. Much of the counselling and guidance centers on the basic physical care, and prevention of illness or crisis appears to be a realistic goal. Kate is alert to areas where preventive teaching can be given. Lack of communication about clients between nurses creates problems in providing consistent guidance. Kate believes that her role is to motivate clients so that they see the need for change. She believes that change that occurs only because the nurse is seen as an authority figure is unacceptable.

Kate's Schools

Kate had a day care center and two schools in her district. The day care was a private institution and she did not have a great deal of involvement. Kate made a visit one day when I was with her to check on the progress of one child but the owner was away at a conference and there was no-one there who could answer Kate's questions. She explained:

> Most of the workers are part-time, the lady we spoke to was the cook, but she serves as a mother figure for many of the children. It is partly funded, and there is trouble with kindergarten age children. If the mothers put the children in kindergarten then day care will not take them after school because they lose out on funds, so mothers who can't find a babysitter have to leave them all day at day care. The facilities are crowded and the kids don't get the stimulation they would in the public or separate school system, and they are the ones who probably need it. The kids lose out in the system. (11/10/79)

Kate does not go to the day care often but there are times when she may be busy.

> Last year I went in and they were bobbing for apples - there was this kid with impetigo! I had to teach all the staff about infection control, send notes home to all the mothers and get treatment started. They kept me busy for several weeks.

Hygiene had been a problem as common bowls and washclothes were being used, so increasing the risk of spreading infection amongst the children, "but I think that is cleared up now." Kate had no authority and had to rely on suggestion to secure change, "but on something like that if it did not improve I'd get the public health inspector to go out."

Kate's schools are Snowden, a public elementary school with over 400 students and St. Anthony's, a small elementary-junior high school in the separate school system. The latter has no kindergarten and has a combined Grade I and Grade II class, so the elementary section is relatively small, as this is the heaviest load in terms of agency programme priorities, Kate spends less time at St. Anthony's than at Snowden. She acknowledges that, "it changes over the year how much time I spend at each school". "Because Snowden has its student files and records organized more rapidly than St. Anthony's, I get my immunizations and priority screenings done at Snowden and then go over to St. Anthony's....On the average however I spend much more time at Snowden than St. Anthony's."

Over the year Kate divided her time by blocks, "First priority screening, then immunization, then health periodicals and in March maturation classes". In the fall she also had to spend time in other schools, "we have our immunization teams and we all go out and immunize at each other's schools". The first week I was with Kate she was busy getting records straight for the health aides to do priority vision and hearing testing at Snowden, the second week it was immunization. In January she was doing regular vision checks on Grade II and Grade IV children at both St. Anthony's and Snowden. In this respect Kate's year did seem to have the regular patterns she describes.

Having a combined elementary-junior high school has some advantages in Kate's opinion, "I spend quite a lot of time in maturation classes in Grade VI, going into the classroom three or four times." This means she, "really gets to know the kids quite well that year" so when it comes to the Grade VII health periodicals, "I'm well ahead, I don't have to start from scratch finding out who's who."

Relationship with Staff

Kate saw herself as well received in both schools. At Snowden the atmosphere seemed relaxed and friendly and communication is open. Kate was teased by the principal and was invited to all social events, such as staff parties.

Principal: Good morning.

Kate: Is it a good morning for you?

Principal: Yes, or it was until the nurses came around. All they do is stick people! Not nice to have at school!

Kate saw working with the staff as critical. "The school is so large I would not find the problems without their help". While she had a regular day assigned for each school she dropped into Snowdon most days. Her first call was to the office to greet Helen, the secretary and Mary, the teachers' aide. "Mary if the unofficial leader around here, she knows what is happening and directs events in her own way." An awareness of the social system undoubtedly promoted communication. After Christmas it was Mary who reported the fact that two students had broken their legs in toboggan accidents and asked Kate to call one of the mothers. Kate said she would:

> I won't go out for a few days. I've found it is like a bereavement, at first all they can talk about is the accident, then when that settles down you can find out how they are coping now.

At St. Anthony's Kate's chief informant was the secretary, Anne. She is an older lady who, "really knows the students". She writes Kate directives about problems. Typical of her messages was one about a boy in Grade VIII.

> Kevin needs new glasses. He has headaches and he has not had his eyes checked since he had his vision checked in Grade II. You need

to ask the mother to get him an appointment to have them checked.

Kate laughed when she read it and said, "Anne fusses sometimes but she is usually pretty accurate in her comments". I asked Kate whether she was going to check Kevin's eyes. "No. If he has not had a check since Grade II he should be seen by a doctor anyway, so there is no point in my doing it." Kate spoke with Kevin and called his mother asking her to get his eyes checked.

At the beginning of each year Kate gave the teachers a check list, telling them what they should observe about children that might indicate a health problem.

> I go to staff meetings at the beginning of the year and talk to all new staff separately. Last year after I gave out the check list the teachers [at St. Anthony's] picked up two kids with learning disabilities both in Grade VIII. Imagine Grade VIII and they hadn't been diagnosed...and one kid turned out to be really bright.

That this type of identification of problems was still taking place was evident. As Kate was leaving St. Anthony's one morning the counsellor came out, and laughing said:

> You can't get out so easily. We have a body in Grade VII who the teacher thinks has eye-hand co-ordination problems. His name is Charles Schmoek.

Kate asked if the counsellor wanted her to arrange to have him tested and she said that, if the mother agreed, she would get Dr. Chivers, the clinic medical officer, to come over to the school "I'll arrange for her to come out half-an-hour earlier so she can talk to the teacher like last time." Kate did not get further information before leaving the school, so had to telephone the secretary to get the mother's telephone number, but within the hour all arrangements for the assessment were made. "If I don't do these things straight off there are other things that become priorities, then I forget". Kate made a note of the appointment in her black book, "so I remember when Dr. Chivers is supposed to come."

Kate also became involved in teachers' problems. This was evident on several occasions. Typical of this was an interaction with Mrs. Trent, an older teacher, who was sitting in the staffroom during a spare period.

Kate: How are things at home?

Mrs. Trent: They are going alright. The orderly comes in for home care each morning. We plan to go on vacation for the Easter break and then my daily help will work full-time and stay with Dad all day and we will pay the orderly to put him to bed.

When Mrs. Trent left the staffroom Kate explained that a few months previously she had looked very stressed and tired, "so I asked her what was wrong." Kate discovered that Mrs. Trent had to get her father up and help him wash and dress before coming to school. Both Mrs. Trent and her husband wanted to keep him at home but she was getting exhausted. Kate put the family in touch with home care "now things are much better...I felt she was so stressed she couldn't be doing the kids in school much good". Kate used her observations to approach the teacher and was able to offer help which alleviated a situation that was affecting the health of the teacher and had the potential for affecting the health of the students. The fact that Kate knows the teachers well was of assistance to her in making the initial approach. When Mary (the teachers' aide) lost her husband suddenly, Kate spent the afternoon at home with her and later was able to help the family identify an appropriate agency for counselling to aid them in recovering from their crisis.

As Kate relied on the staff so heavily for initial detection of problems and screening her interpersonal relationships were critical to her chosen method of operation. She saw helping staff as part of her mandate, for her, "my client is the school".

The Time Bind

Kate really felt a time-bind in relation to her school programme. "I feel I would like to do a better job, but I can't because of my time restrictions." She believed educating the children to be critical yet, "I feel I am barely touching it." She would love someone to give her two months and say, "do all the health education you can in the school, that's all you have to do." She would like to use the time to, "make a really good package" for the students.

Kate sees clerical work as taking up much of her time. Snowden has a high student turnover, so every morning when she goes in there are new records to be obtained. Because many of the children come from outside the city immunization consents must be obtained. As classes are large preparing lists for vision screening and immunization takes a long time. Immunization takes half-a-day, but the paperwork, parent contacts and follow-up takes at least three working days. Kate also had homes in which English was the second spoken language and a telephone call was often inappropriate as a way of obtaining information. So Kate either had to arrange for a home visit or get the parents to come to the school.

Another problem with school work is that clinic and home visits must frequently take priority:

> Snowden is such a big school with so many problems and time is so short. We were just talking the other day...I worked clinic twice and was on stand-by once and we had a regional meeting and I was involved with visits, I was lucky if I got into Snowdon for half-an hour - that's why I must rely on my teachers as part of the referral system...it's critical to me. (22/2/80)

Kate told me that there was talk of having extra clerical help in the clinic to help the nurse in the schools, "I can't wait to get rid of some of this paperwork." Despite her aversion to the paperwork there are times when she records more than is required, "I am not obliged to chart on the teacher-nurse conferences, but I do chart all kindergarten problems...otherwise they get lost and don't get followed through." This particular charting is compatible with her concept of prevention of illness by attending to problems before they become serious.

Teacher-Nurse Conferences

One of the activities that involves the teacher in referrals is the teacher-nurse conference. Prior to the conference Kate gives each teacher a guide. She does this, "about a week before the conference". Kate says, "I don't get that much of a turnover in the teachers...but when there is a new one the best way to get to know them is a teacher-nurse conference." With teachers that have been there for sometime, "I'll maybe not do one all year...if I know they are really good with referrals, and they seem in the past to have been accurate with referrals." Within the teacher-nurse conference Kate must set priorities and she has decided spending time with new teachers is essential. Her second priority is, "going over the kindergarten kids" because "then I will know potential problems entering the school."

The guide Kate gives the teacher suggests they observe the physical appearance and behaviour of each child. They are asked to report anything about home environment or parenting skills they may have noted and whether they have concerns about absenteeism, clothing, nutrition or the child's toilet training. Kate also asks the teacher to tell her which children come from single parent families. Kate said, "We have a yellow sheet at the clinic we can give to teachers, but it deals mainly with physical things, so I prefer this guide". She noted that if she warned the teachers about three days ahead, "I find one gets a much freer exchange of information".

I observed a teacher-nurse conference on the two kindergarten classes at Snowden School. Speaking of the teacher Kate said:

> Her assessments are reliable. I know that if she says a child needs special placement for example, he will not need additional assessment. Her judgements are sound.

When Janet came in she was obviously well prepared for the conference and had her comments written on the class list. Before she began going over the list Janet said:

> I have a new child transferring from Richmond School, the kindergarten could not cope with him, but I said I would give it a try. He was a behaviour problem - no discipline at home, a young mum, but I hate to see a drop-out in kindergarten, so as I had a space I said to bring him along. (7/1/80)

Kate told me that other mothers in her area who had children at Richmond would like to get them into Janet's class. She laughed about the young mother, "Janet thinks the Mum's are young when the children enter kindergarten, she should see them on a post-partum visit!"

Janet began to go over the children in order and it was evident that she knew them well.

> Janet: Terry is very immature. She's slow, sluggish and just generally behind for her age. It takes her ages to even print her name...she's kind of lifeless.
>
> Kate: I could make a home visit.
>
> Janet: I'll be doing my interviews soon.
>
> Kate: Maybe I could see the mother the same day.

Janet: Because of what I told you?

Kate: Yes, but also from the day I showed the films, she seemed odd, sort of spaced out.

Here Janet and Kate pool their information and Janet then said, "I will let you know when I will be doing my interviews." Janet then told Kate about Corey.

> Corey has had pneumonia twice and was in hospital. His mother has taken him to the specialist and he is being looked after. I think she is a single parent and often she sleeps in. Corey arrives without breakfast but with a sandwich he is meant to eat at recess. He has poor clothes but I think the mother is doing what she can.

Kate asked Janet to let her know if she had any further concerns about Corey as the year progressed. The next few children gave rise to no concerns, they were settling into the classrom and the family circumstances seemed satisfactory.

Janet: Christopher! I don't think he is stimulated at home. I think I could bring Big Bird in and he wouldn't even laugh.

Kate: What is his attention span like?

Janet: I don't think he has one.

Kate: Let me see if I have his record (checks list). I have it marked down (goes to filing cabinet). But I don't have it. It may be with my screening (checks another pile of records). (Laughs). Janet gets all the problems. In the other kindergarten...that's the Ukrainian class...the children are usually well-cared for...immunizations up to date.

Janet: If they go to the Ukrainian class and have a behaviour problem I get them within a week. They say they can't teach a second language under those conditions (laughs). Maybe it is true!

Kate: Maybe it's because you're such a good teacher (both laugh). Oh! he's a diagnosed epileptic - no seizures. I wonder about medication. I'll check on that. Have you talked to the mother about special placement?

Janet: No, I'll talk to her this month.

Kate: I'll go and see her after you have seen her. Once she knows where the kid stands in school.

Janet: Why don't you get a medical done on him at school?

Kate: I could ask the mother about that (makes a note in her black book).

In the conference Janet showed that she was able to utilize the guide to identify children that Kate needed to follow-up. There was obviously a good working relationship and Janet felt free to make suggestions as to what she would like to see happen. The interview demonstrated the interrelationship of health and school work and the need for teamwork between the nurse and teacher. Kate assessed Janet as a reliable informant.

Teacher-Nurse Cooperation

Another example of teamwork was in the health care of Cindy, a Grade I child who Kate had identified as being overweight at the beginning of the year. "When she came in to see me her poor little arms stuck out, she couldn't get them in close to her side." When she observed the child Kate was sure "she had a metabolic problem or something...she didn't look as if she was just overweight."

> I tried to get the mother to take her to Dr. Chivers because her doctor was Dr. Bevan. There are two doctors in this area Bevan and Walters and to me they seem to be not too thorough. I sent David, a chronic wetter, to them - they did not take a urine specimen or anything, just told the mom not to worry. Usually the moms will agree to let the child see her [Dr. Chivers], but not this time. Dr. Bevan saw her [Cindy] and said it was okay - she would grow out of it...but the teacher and I were both concerned, we both had to work real hard with the mother and finally got a referral to the internist. The teacher talked to Mom and I home visited...and finally we got some results.

Cindy was admitted to hospital, investigated and placed on a diet and exercise regime. Once the mother was convinced there really was a problem she was most concerned. She visited her daughter daily in hospital and learned about the child's treatment.

> When Cindy was in hospital the sister brought sandwiches. [Children] can't eat in school unless they live a certain number of blocks away. [The principal] did not know all the trouble we had had and he saw the sister eating lunch and called the Mum and said the sister couldn't eat lunch. [The teacher] told him what had happened and he felt so badly, so he got her to phone the Mum back and say it was okay.

Here communication within the school had broken down, but the problem was speedily resolved once it was discovered. In February Cindy was back in school and the mother had sent the teacher a note to say the little girl was on a restricted diet and was irritable but, "the doctor says to expect that". She also asked the teacher to let her know what she could do to help Cindy catch up in school. The teacher said, "the grammar and spelling in the note are something else, but the message is encouraging." Kate said to me, "It took some time and effort to get things moving but to me this was satisfying - she might never have been picked up [as a health problem] otherwise."

Teachers' Referrals

I asked Kate whether there was a difference between the co-operation she got from teachers at Snowden and St. Anthony's when it came to referrals. She replied:

> Both groups [of teachers] are good. Referrals might be more noticeable at Snowden because there are more children and more problems. I know if there is a problem at St. Anthony's the teachers come but I think there are less problems. I think if the teachers in

St. Anthony's were in Snowden the referrals would not alter - it's the school not the teachers. (22/2/80)

It was not unusual for Kate to walk into the staff room at Snowden and be greeted by several teachers who had children with health problems, particularly if it was break time. On one occasion three teachers came over the moment she walked through the door. (28/1/80)

Janet: Will you take a look at this little boy in my class...he has a sty I think. I have sent a message to the Mum but nothing seems to have happened, he has had it for a week and a half now. It's Henry Cheung...a neat little kid. His eye looks sore, but he says it isn't.

Mrs. Hearst: (Grade IV) I have this boy with a sore on his chin...it seems to be getting larger, will you take a look.

John: There's this boy in my class, Allan, who has sprained his thumb...will you take a look?

As soon as recess was over, Martin, the boy with a sore chin came down, sent by Mrs. Hearst.

Kate: (Looking at chin). How did this start?

Martin: I dunno. Can't remember hurting it or nothing.

Kate: Have you been picking at it?

Martin: It sure gets itchy - then I scratch it.

Kate: The main thing is to keep it clean. Wash well in the morning and night and keep a cloth just for your face.

Martin: I do.

Kate: You can get your Mother to put some ointment - some Neosporin on it. I'll write it down and you can give it to your Mum.

Kate writes it down, then comments, "His Mum should be able to afford it. There's a Dad in the home and he's working. In my area you always have to think of these things." I asked Kate whether she contacted the mothers:

> Ideally I would like to talk to them all, but I don't have time, so with Martin, he's Grade IV, I reckon he should be able to take a message home, but up to about Grade II I always talk to the Mum myself.

Kate went along to the kindergarten to find Henry, a young Korean boy. He had a swelling the size of a large pea on his left eyelid.

Kate: That must hurt Henry.

Henry: (Shakes his head).

Kate: Is your Mum at home?

Henry: (Shakes his head).

Kate: Come along to the office with me and we'll see if we can talk to your Mum. Have you been to the doctor?

Henry: (Shakes his head).

Kate pulled Henry's record and looked at the information. She mused, "I wonder how well Mum speaks English...I'll try and get her." There was no response, so Kate pulled out her black book and made a note, "I'll call this evening." She returned to class and Janet said, "Did you find out anything." Kate, "No, there was no one in. I don't think mother speaks much English." Janet replied, "Oh yes, she does, she's really very good." Kate disliked calling parents when she thought she would not be able to make them understand. At St. Anthony's she got the vice-principal to call some parents for her because she knew he had been teaching them English in night school and said, "he understands their accents better than I do."

Kate did get in touch with the father and Henry was duly taken to the doctor. Next day the father called and said, "Doctor pricked the eye and much fluid came out". Henry was also placed on antibiotics. Kate said, "I can't understand why it did not hurt...it must have interfered with his vision". She understood why the parents had not acted before as both were working full time but found "they were co-operative when I suggested it." (31/1/80)

Frequently Kate had to follow up school problems in the evening as the parents in her district all work. The alternative was to call them at work, but they were not always accessible, as many of the men were labourers and the mothers worked in service occupations, such as waitressing. Kate told me that the day before at St. Anthony's she had six referrals, "of course I have not been in for a while". With older children the problems were more commonly related to possible learning disability or a child who had missed a lot of school. However, at St. Anthony's Kate did get called in to see the children in the younger grades with similar problems to those at Snowden. Anne, the secretary told us one teacher wanted us to look at a child with frostbite. We went down to the classroom.

Teacher: Jamie came in screaming, his hand really hurt. it was cold (-30°C) and his gloves were thin...so I put it in warm water. Would you take a look at it?

Kate: It feels hot, it looks white. (To Jamie) Does it still hurt?

Jamie: (Nods).

Kate: Is his mother home?

Jamie: (Nods) Yes.

Kate: You need warmer gloves to come to school when it is this cold.

Teacher: Was it alright to put his hand in warm water?

Kate: Well, you have to be very careful, because there is no feeling, so don't use running water. The hand seems okay now but watch it. It doesn't seem to have been frozen, but it was a near thing. Perhaps you could send a note to his mother. Does he have far to come?

Teacher: About three minutes - but he was probably waiting to get in.

Kate was home visiting that afternoon and had only called in to the school to get a telephone number she had forgotten. She commented, "I suppose I could have contacted the Mum but I know I can trust [the teacher] to send a note home.

Trusting the Teacher

Kate feels teacher co-operation to be essential in the schools and so she spends time educating the teachers both regarding referrals and in treatment of minor ailments. At present one teacher at Snowden has a first aid certificate, "so they have a resource as most of the time I'm not there". For Armistice Day the children had a memorial service in the gymnasium, Guides, Scouts, Cubs, Brownies, Pathfinders were in uniform and had their colour parties. The French and Ukrainian language groups sang "O'Canada" and "God Save the Queen" and a veteran spoke on the meaning of Armistice Day. There was even a bugler to play "The Last Post". The excitement proved too much for some children and several fainted or had to be taken outside. Although Kate knew this she did not intervene. In particular a teacher told her about one girl whom she had had to take outside into the fresh air.

A few weeks later she was just leaving the school when Mary (the aide) came running out of the office and said, "It looks as if there has been an accident, two girls have just gone to the washroom and one was bleeding". Kate put down her belongings and went to check. One of the girls had been hit in the face by a floor hockey stick, she had a bruise, but no other damage. I asked Kate why she had not checked on the children at the Armistice Day celebration but had done so with the accident. She recalled the one child about whom the teacher had spoken.

> Well, when the teachers told me about the fainting they were telling me more as a sort of story "Kate, this girl fainted..."like obviously they had handled the situation, it was cared for and was no big problem....If it had been, they would have said "Kate, a child fainted and we are worried about her", sort of thing. Whereas with the other children I really didn't know what the situation was. When I first came to Snowden I didn't know how reliable my teachers were, so it was necessary for me to see every single child and not really trust the teachers....I didn't know whether it would be more serious than they indicated. [Now I know] which teachers to rely on...it does vary, but the teacher that mentioned it didn't see it as a big deal...they would have let me know for sure if they were worried...so I felt it unnecessary to check. (22/2/80).

Kate knows her teachers well and after two years feels she is able to judge when she must follow-up a situation and when she can take the teachers word that all is well. This is one of the strategies she has developed for coping with the workload and she utilized it as a guide for setting her priorities. Throughout her work in the schools she relied heavily on the teachers and there was evidence of co-operation between nurse and teachers in both Kate's schools.

Records - A Source of Frustration

In early February Kate was working on records in both Snowdon and St. Anthony's. During the clinic workshop she had got behind and she had transfers from other schools as well as follow-ups from Grade II and Grade IV vision testing.

> I'm sure there must be a better way to handle this. In the East they have computerized records. If I didn't have to do all these things I could do more nursing. (1/2/80)

I asked her what she meant when she said "more nursing".

> Well, I really think we should be doing prevention. Getting out from the schools before there is a problem. Now I go [out to homes] because something is wrong.

When Kate had been doing vision screening on the Grade IV children a boy had come in barefoot, which was against school regulations, so she had sent him to get his boots. When he came back there was a leak in one and he said he had no socks because they were all dirty. Kate suggested he needed socks as the weather was cold (-20°C) and talked to him about washing them himself. She now used this as an example of what she would like to do given the time.

> You remember Robert, with the leaky boots? I don't know whether he leaves home with shoes and doesn't wear them, or whether his boots were new and he made a hole in them, so he can't have more, or whether finances are the problem. Does he have socks or does he just lose them? I dealt with the immediate problem and that may be all there was to it - but with the workshop the records have piled up and now I don't have time to go out. I meant to go home visiting this afternoon, but I have to go into the clinic to get these records done. (1/2/80)

Kate may be somewhat compulsive about her records. Hazel, who had the adjoining district told me, "I leave my records until teacher's convention and take the day when the kids are out of school." It is, however, a real source of frustration for Kate that records need to be completed and that is at the expense of "real nursing".

Kate recognized the need for getting records transferred, particularly at the elementary level. When she got one record from Ontario she found that Joanne, a Grade III transfer, had been treated for tuberculosis. A younger sister, Constance, had cerebral palsy, but was not in the school. They had been in rural Ontario, Kate remarked, "They were really up in the boonies" and made the assumption "they must have had a father that worked." In Kate's area this observation is of significance, with so many families on welfare or with a single parent in the home.

When she called the mother she found that Constance was registered at the Glenrose.

> Joanne was on call-back at the T.B. Clinic in Ontario but there was no referral here. That surprised me. I gave the mother the number for the Aberhart and told her to call. She seemed to think it odd that there was no mention of a follow-up, but not enough to do anything about it. I think she will follow up because she seemed interested and returned the health form immediately - and that's always a good sign. (1/2/80)

Kate discovered Joanne had only had two measles shots - which is considered inadequate. She did not know whether the vaccine was live or killed, so decided to call the immunization consultant for advice, "She really knows her stuff and can usually give you the answer right away."

Without the record Kate would not have realized that Joanne needed referral for tuberculosis follow-up. There is also a need for accurate information on immunization status of the children. The complaint is not that the records are not required, but that much of the work on records could be done by clerical staff, as Kate said:

> I doubt if anybody enjoys it. It's the only part I don't really like. If I wanted to do it I'd have been a secretary or something. I doubt if any of the nurses really like having to do records. (10/1/80)

In assessing the mother's interest in her childrens' health Kate used the fact that the mother returned the health form as soon as it was sent to her as an indication of concern. I asked her about this and she told me, "I've found that the concerned mothers don't delay. If you have to keep calling and getting after them, then health is usually a low priority on their list."

The Effect of Context

Kate obviously preferred working at Snowden. When she first described St. Anthony's she said:

> Wait until you see the nurse's room...it is closed in and has no windows. Generally it is too cold to work in and I have to immunize or do screenings in the gym. (21/10/79)

In January both Kate and I sat with our coats on when she was working in the office. The room was tucked up in a corner behind the stage, so the children had to make an effort to find it. There was no chance of anyone just dropping in.

In contrast the nurse's room at Snowden was in the mainstream opposite to where the younger children left their boots when coming from outside. It too, had no windows and at recess the draft from the main doors blew in and it was cold around the ankles. Kate did not complain about this room and somehow it did not seem as cold and dreary. Kate also used the staff at Snowden as her social support system. The distance of her district from the clinic did not encourage her to return for lunch. As she felt uncomfortable with line-staff relationships in the clinic, she also preferred to stay away unless it was necessary for her to visit. She did telephone regularly for messages. She knows her feelings about clinic have been obvious, particularly to the school secretaries.

> Lately I have been using the school as a support system, I am very conscious of that and I don't like it. I feel guilty if things aren't going well in clinic...and I am not meeting the school's needs by telling them what's happening. The school is my client too. But sometimes you get a phone call and you have to take it in the office, and the secretary knows you are annoyed or upset...and they say "What's wrong"...and you tell them because you are upset. If things were better in clinic I wouldn't talk to them...I guess at the moment I'm meeting my need. (28/11/79)

Kate is torn between her desire to treat the school as a client and her own need for some support. The conflict she feels in the clinic has also, to some extent, influenced her decision to utilize her school as a headquarters within her district but she keeps in touch with the clinic so that messages are not delayed in reaching her. When I was observing she would call at the beginning and end of the morning and in the afternoon and she would always let the clerks in the clinic know if she changed her plans, so they knew where to find her.

I asked Kate if there was a difference in the teaching activities she undertook in the two schools, because of the difference in students.

> Well, the two schools are different. At St. Anthony's there are a lot of Chileans, Italians, French, all with English as a second language and usually Catholic families with many children in each...but not the welfare and single parents like Snowden. (28/11/79)

A check of the register of the elementary grades showed the mixture Kate decribed, Courteille, Guay de Costa, Carlos Requelme, Vido Horek, Manuel Szabo, Mark Van de Mark. "This influences what I do in clasroom teaching and so does the age group." At Snowden Kate focussed more on dental care in kindergarten and Grade I, "that's the time to get them to brush their teeth regularly". At St. Anthony's Kate focussed more, "on smoking at the Grade VI, VIII and IX level."

> Part of it too is the teachers' requests...at St. Anthony's there is not a hygiene problem, except for one family, at Snowden it is a bigger problem, so I deal with it in class.

Kate had some packaged material on hygiene and one of the teachers at St. Anthony's had been using it with one family, a boy and a girl, as an extension of the health curriculum.

> I thought with only one family involved it was the best way to go. The teacher was willing to try it...but it didn't work...she has

> tried since January and it just did not seem to make one bit of difference. (22/2/80)

I asked Kate if she had been to see the mother. "No, I didn't think it would make any difference...that is why we decided to work with the children...I've talked to her before."

Kate adapts her approach depending on the priorities in the schoool, examining both student needs and teacher capabilities. She sees the children at St. Anthony's as "better cared for...the parents are more concerned about them" compared to most of the children at Snowden, which is one reason why "hygiene isn't an issue" at St. Anthony's School. She showed that she tried to carry through her concept of the needs of individuals into her group teaching.

Assessing Clients' Needs

Kate was completing her Grade II and Grade IV vision checks at Snowden and St. Anthony's. She saw this as "a real area of prevention... you expect to pick up about 1 in 4 children in Grade II and 1 in 6 children in Grade IV who need referrals." At St. Anthony's in Grade II there were 5 out of 16 children who needed referral, which was close to the estimate. During vision testing Kate's focus was on the task in hand, she did not routinely explore any health concerns as part of the visit with the children. However, she did make observations on the child which she used as a basis for exploring future needs. She had large classes to screen and the children came out of class two at a time, when the first pair returned the next pair came down, it was a bit like a conveyor belt.

Kate: What's your name?

Student: Shauna.

Kate: Shauna what...?

Shauna: Budden.

Kate: What I am going to do today is test your eyes. Did the teacher tell you when she sent you down?

Shauna: Yes.

Kate: Have you been to an eye doctor at all?

Shauna: No.

Kate did the test, asking the student to stand on the line and read the chart, first with one eye covered, then the other. She then got Shauna to sit down.

Kate: Put on these funny glasses and then look at this picture and tell me which doughnuts you see popping out.

At the conclusion of the test she wrote on a piece of paper saying "You're all done. Will you take this to your mum?" She did not comment as to whether Shauna's vision was satisfactory or whether she needed further follow-up and Shauna did not ask. This was the standard procedure for the interviews. If a child had difficulty seeing, Kate would ask, "Where do you sit in class - the front or the back?" There were some exceptions to this pattern with the Grade IV students, one of these was Robert. First Kate noticed that he had a chipped tooth.

Kate: Have you been to the dentist lately?

Robert: Yes, when I chipped my tooth.

Kate: How did it happen.

Robert: I banged it on somebody's head.

Kate: In school.

Robert: Yeah.

Kate: When did it happen?

Robert: Last November. I'm going to have it capped when I am eighteen.

Kate: Were your parents upset?

Robert: Yeah, they took me to the dentist right away?

Following this conversation Kate checked in the office to see if an accident report had been filed with the School Board. She was upset that she had not known about the chipped tooth when it happened. The form had been completed at the time of the accident however, so all was well.

Later she saw a girl who she judged to be overweight. "I must phone her mother and see if she is interested in helping her lose". Kate herself is very concerned about nutrition and exercise and she watches for signs of early excess weight amongst the students and tries to get them referred for help.

> I've been referring mothers and children to the programme at the "Y". It's for both the mother and the child and it's only $15.00... so most of my mums can afford it. Many of the Portugese mothers work on Saturday, and all the girls tend to be overweight, but I try and get them to send the child with someone. It is better if the mother goes too, but if she can't at least the child gets some counselling. It's a good programme...it deals with diet and exercise. Money is a problem with many of my families...but $15.00 is not out of sight. (7/1/80)

Kate's own lifestyle was reflected in her concern about excess weight in young children. She located the resource that she believed would meet the needs of her clients, both in terms of the content offered and the expense involved. She recognized the fact that she does not have time to become involved in individual counselling, "but the children need something now...it's too late by the time they are hypertensive." Her focus on prevention is obvious in her approach to weight control. She does not rule out the possibility of a group teaching session however, and at the end of the morning she commented on Shelley, a Grade IV student who had been in earlier:

> Did you see her teeth? They were poorly spaced and not at all clean...I must follow-up on that. It is a good time to note these things. She was a bit overweight too...if I find several students I may do some nutrition classes later in the term.

While Kate is doing vision screening she does observe the children and uses her observations as a source of needs assessment for future intervention. She does not become involved in teaching during the vision testing session itself, but as she had over forty children to screen this appeared to be realistic.

Summary

Because Kate viewed her work load as unmanageable she developed coping strategies for ensuring that she detected problems amongst the children at an early stage. She relied on the teachers in her schools to refer children to her and at the beginning of the year she taught them the signs and symptoms that indicate possible health problems. She viewed the school as a client, this includes health care of students, teachers and their families. Kate organized her year around the agency programmes that must be completed but also found time for classroom teaching. She tried to base her teaching upon individual and group needs, although in the latter case she tended to base her classes on the teacher's assessment of the situation. Kate used her school as her social centre and this may be a factor in the free interchange between the nurse and the teachers that can be observed in her schools. She utilized her own observations as one basis for determining client needs.

In intervention she involved the teacher in a co-operative approach when this would help to meet the client needs. Her major frustration is paper work, which she feels take time away from nursing activities.

The difference in the family situations of the students, and the age range did affect the content of health teaching required in the two schools. The situation of the nurse's room in St. Anthony's inhibited student contact with the nurse and tended to isolate her from the school population.

The Clinic

Kate spent more time at Richmond Clinic, which mainly attracted clients from her district and from the adjoining district, than she did at Greenfield clinic. I asked Kate how she set her priorities for a family coming into clinic.

> Well, I look at the birth notice...gives me an indication...I know right away if it is a baby at risk for instance. If there is a birth defect...the physical examination would be a priority...if the baby is two months of age I want to know has the mother taken him back for a two month check...? If not the physical would be a priority.
>
> If a mum comes into clinic, the baby is six weeks old, she saw the doctor yesterday, my priorities change. The first thing the mum says, maybe is, "What I want you to tell me is what should I be feeding my baby." Nutrition is obviously a priority with her...so it is a priority with me too. Depending on the clues she would give me...that's how it would be.
>
> Then there's things that are priorities to me that are not priorities to them...and that's when I spend time trying to make it a priority for them...to say to them "Have you thought about it?" (29/9/79)

Kate's major focus remains centered on her belief that it is important to meet individual needs. Kate then moved on to say she must also try to make the client recognize the importance of priorities that

Kate thinks important but which the client herself may not have identified.

Developing a Profile

When Kate did not know the client she introduced herself as she brought the client in from the waiting room saying, "I'm Mrs. Kate Flemming, I'm the Community Health Nurse you will be seeing today". While I was with her she went on to say, "and this is Peggy Anne Field, a nurse-researcher, and she would like to observe the interview and will talk to you about the study." This introduction was almost ritualistic, not varying from client to client. While I explained the study and obtained a consent, Kate would glance at the record. Andrew Christopher and his mother were clients of Kate's early in this study. Mrs. Christopher was slim, with dark hair, she was wearing slacks and a leather jacket. She sat with Andrew comfortably settled on her knee. (11/10/79).

Kate:	How old is Andrew now?
Mrs. Christopher:	Six and a half months.
Kate:	Has he been to the doctor lately?
Mrs. Christopher:	Er...at five months he saw the doctor.
Kate:	Have you been having any problems with him or anything?
Mrs. Christopher:	Um...he's got two teeth.
Kate:	Oh, good.
Mrs. Christopher:	Two bottom.
Kate:	Can you show them to me Andrew?

Mrs. Christopher responded to Kate's question as to whether she had had any problems by saying "He's got two teeth". Kate missed this cue and did not find out whether the teething had upset the baby, she responded, "Oh, good" and looked in Andrew's mouth. Then she went on to ask, "How was he with his immunization?" The mother indicated there was no problem. Kate noticed he had a runny nose.

Kate: He's had a cold?

Mrs. Christopher: He's had a cold...last week. It took him a long time to get over it.

Kate: Did he lose weight do you know...or his eating pattern...did it change at all?

Mrs. Christopher: When he had the cold, for a couple of days he didn't eat very well, but he's back to normal now.

Kate: Let's see whether his height and weight are (plots it on growth chart)...he's tall (75 percentile)...did the nurse do a developmental test last time?

Mrs. Christopher: Ummm.

Kate: (Showing Mother chart). His height and weight are both good. This is where they were the last time. He has come right down to where he should be...so that's good.

At the prevous visit the height had been at the 75 percentile on the growth curve, the weight at the 90 percentile. What the nurses try to achieve is to keep height and weight on the same percentile. Kate did not check to see that the client understood this. At this visit Andrew's weight and height coincided.

The Client's Concerns

Kate proceeded to check with Mrs. Christopher about Andrew's diet. Mrs. Christopher described his diet, then said "I really don't know what to give him for lunch".

Kate: Right now you give him fruit and vegetables?

Mrs. Christopher: And meat. Beef and chicken. For supper he gets...I make my own food, chicken, potatoes and carrots through the blender and then another vegetable and then fruit.

Kate: Did you introduce different fruits and vegetables gradually?

Mrs. Christopher: Yeah, one at a time.

Kate: Have you found one he does not like yet...or is he not fussy?

Mrs. Christopher: Not unduly...he eats all of them. He likes what I make better than the baby food.

Kate: That's good. Plus you don't have any added sugar...or salt?

Mrs. Christopher: Nope.

Kate: Have you given him any egg yolk yet?

Mrs. Christopher: No, I haven't.

Kate: He could start that now...he's six months...but just the yolk and not the white...the reason is the white has enzymes in it and they are a little sensitive to it...they may get allergies, so it's better to wait for awhile.

Mrs. Christopher enquired about cooking the egg and Kate suggested poaching or soft boiling the egg. The mother then said again "What can I give him for lunch?" Kate produced a feeding guide for six months of age and went over it with Mrs. Christopher, "the amount they take is not as important as the variety." She checked to see Mrs. Christopher knew the

Canada Food Guide and that she was familiar with the basic foods groups, then said, "make sure you offer one food from each of the four basic groups".

Here Kate's need to assess Andrew's current eating pattern resulted in Mrs. Christopher feeling that her question was unanswered. When she raised it again Kate checked her general understanding of nutrition and provided a suggested feeding guide. As the mother looked at the guide she commented on various suggestions.

Mrs. Christopher: Dry toast...he doesn't like...he doesn't chew on it at all...he seems to choke on it.

Kate: That's okay...if it doesn't agree with him leave it and try it later...there is no point in forcing him to take anything he doesn't like....

Mrs. Christopher: And what about boned fish? What kind of fish?

Kate: You can give him...er,...er...shellfish isn't a good idea because a lot of children have allergies...but...tuna is fine.

Mrs. Christopher: Canned?

Kate: Wash it out...just put water over it the same way you do with canned shrimp...but any of those are fine...just as long as it's deboned.

Kate did not provide the mother with much information. She really only mentioned tuna, ruled out shellfish and then said, "any of those are fine". She went on to suggest that cottage cheese and yogurt were good protein sources. Mrs. Christopher responded, "I wondered about yogurt"

Mrs. Christopher: How much milk should he be drinking?

Kate: He should probably be down to twenty ounces now if he's doing well with solids.

Mrs. Christopher: Yes, that's about what he takes...and he's on two percent now.

Kate: Is he? Were you diluting it with water?

Mrs. Christopher: No, (pause) was I supposed to?

Kate responds to the tone of her client's question by saying:

> Some people have diluted milk for their babies. If you haven't been doing it that's fine, and you've had no problems. but I was going to say it is no longer necessary to dilute it at six months of age.

Mrs. Christopher explained that when she went to the doctor he had told her to put Andrew on homo, but the milk did not agree with him at all, "he was throwing up all the time". She decided to switch to 2 percent and had no further trouble. Kate begins to negotiate with Mrs. Christopher.

Kate: Have you tried him on homo since?

Mrs. Christopher: No.

Kate: You haven't eh...you maybe could just try him...with a little bit...and see how it is...

Mrs. Christopher: Is there much difference between homo and 2 percent?

Kate: Well, the difference between the two milks is that 2 percent has some of the fatty acids removed and so it's lower in calories. For us [adults] we say 2 percent is better because we're cholesterol conscious and calorie conscious. Babies need those aminolaic acids, so whole milk is not harmful for them and can be better for them, their bodies don't manufacture the acids...so they need that fat. I expect the regurgitation was the milk change generally...not particularly homo.

Mrs. Christopher: No...I left him on it over a week and he was still doing it.

Kate: Was he? Well try him just maybe one feeding... try homo instead and see if there is still a problem with it.

Kate found the family drank 2 percent and not homo, so the mother would have to buy milk specially for the baby. She went back to the growth curve and said, "He has lost a little weight in proportion to height" so "just try homo and see". Kate did not clarify the connection between these two statements. Mrs. Christopher replied "Mmm", but made no commitment to changing.

The baby was drooling and Kate returned to the question of teething and said, "Does he have trouble with it?" Mrs. Christopher admitted that "some days its pretty bad". At this point Kate explored ways of helping a baby with teething...the problem mother had started to raise early in the interview and which Kate failed to recognize as a cue at that time.

Mrs. Christopher mentioned that Andrew gets a bad diaper rash when he is teething, Kate checked this out and found it was clearing up. As she undid the diaper she talked to Andrew.

> Kate: Oh, you're grabbing at everything aren't you? (laughs). Oh, yes, you're big aren't you? (laughs) Is your room child proof yet?
>
> Mother: (laughs)
>
> Kate: Strong too...aren't you.

Here Kate introduced the topic of child safety but failed to capitalize on it. She returned to the topic of the rash, giving the mother information on why this is a common problem in relation to teething. She explored Mrs. Christopher's management and reassured her that she was doing all she could and that obviously the rash is improving. Kate then proceeded to immunize Andrew. When she came to give the injection she did not check out sleeping or arm preferences but said, "It will be in his left arm". This seemed to be standard with all the children immunized and appeared to be a contradiction of her concern for adapting care to individual needs.

> Okey, dokey, Andrew. No! Maybe Mum can hold that other little arm (child grabs for syringe). No doubt he can reach it around (to Mother). No! No! No! (to baby) I'll just hang on to the arm

> myself I think, just a pinch Andrew. There we go. There we go (baby cries). (Nurse distracts baby with bell). You like my bell? You like my bell? We'll have to give Mum one of those.

Mrs. Christopher picked Andrew up and put him against her shoulder, patting his back and he quietened quickly.

> The next time you're due back isn't until a year for his measles...as far as his immunizations go. Then we give a booster..a year from now for diphtheria, whooping cough and tetanus...so that won't be until October 1981. We would like to see him back in clinic about eight months of age, so we could do the developmental test, if you can make it.

Kate focussed on Andrew during the immunization and was responsive to him as a person. She instructed Mrs. Christopher on the clinic schedule, suggesting she come back for a development assessment, but not explaining why this was seen as important. As Mrs. Christopher was leaving she added, "I'll put down the time for immunization so you know when to come...but don't wait until then if you have problems in the meantime."

Following the visit I asked Kate what she thought was important in the interview. She said "I think what was important was what she [Mrs. Christopher] raised, the diaper rash and his diet. I thought that was important to her". This is consistent with Kate's belief that her focus should be on meeting the client's needs. While at times she missed cues she did respond and spent time on the mother's concerns once they were identified.

Assessing Family Function

In speaking of the visit Kate indicated that if the mother had not raised the topic of nutrition she would have done so as the baby was six months old. "I'd also be interested in development, in terms of stimulation, personal-social development and the mothering role". The social situation was also of concern to Kate. One concern was whether the mother had a reliable baby sitter. Kate thought she was very conscious of social factors because many mothers in her area were having difficulty adjusting themselves to having a new baby.

> You know, you go and visit and about this time [six months] the delight of the new baby is wearing off...and they're going through a stage of being frustrated. The baby's at the age when they're beginning to get into everything and they're not quite as convenient as they were at the age when they were sleeping straight through... except for feedings every four hours...so I try and find out about that.

> I asked Kate how she felt about Mrs. Christopher:

> Well, I would have liked to ask her more questions, but just because it is the first time being taped I was conscious of her reaction to it...but I found that her concerns were fairly typical for a baby of six months of age. He was getting teeth...and diet...she didn't say anything to me that would indicate she was having problems with him, you know, role of mother, the husband's responsiveness to the baby or change in lifestyle...I would have liked to ask more questions to find out if it's true that she is managing...I'm assuming because she didn't mention it it's okay...but I would like more information before I make that assumption...that everything's okay at home....I haven't had a chance to read the nurses's reaction to her before. [on her previous visit to clinic] (11/10/79)

This reluctance on Kate's part to ask questions, which might be construed as an invasion of the individual's privacy, appears to be a pattern. On her visit to Louisa Lubbertz and on her hygiene visit she had expressed similar feelings. She recognized that she had insufficient information for assessment and intervention but seemed uncomfortable in obtaining the necessary data.

In assessing the maternal-newborn relationship Kate showed that she had observed the non-verbal behaviour that occurred during the visit.

> [Mrs. Christopher] seemed responsive to the baby...she smiled and was obviously delighted by the things the baby was doing...that the baby could smile...she had good eye contact with the baby when she was doing up the little pyjamas [after the diaper rash had been

> checked]...she was holding the baby close to her. She seemed to show loving and tender gestures towards the baby...she didn't seem frustrated by the child's active grabbing at everything...she seemed humoured by it rather than frustrated...you know, unhappy...by it. His sucking at her jacket didn't seem to ride her at all...she just went on and absorbed it...and that to me was a good sign...she seems very patient with him.

From her observations Kate felt satisfied that the mother and baby had a good relationship and did not feel any further follow up was needed before the mother returned to clinic the next time.

Social Assessment

Mrs. Sherwood brought her 10 month old daughter, Lindsay, in for her immunization, this was behind the normal schedule and Kate discovered that this was because she had been away in Ontario on vacation. Mrs. Sherwood had had Lindsay to the doctor, so had not had her weighed at clinic. Lindsay had had an ear infection on her previous visit, so Kate checked to see this had cleared up. She checked on her social development using the Denver Developmental Test, then gave the oral polio vaccine. She then started to explore Mrs. Sherwood's home situation.

Kate:	Are you with her full-time or...?
Mrs. Sherwood:	Yeah.
Kate:	Are you still living with your parents?
Mrs. Sherwood:	Yeah.
Kate:	How's that working out is it okay.
Mrs. Sherwood:	Oh yeah, it's okay. Sometimes it's not too...I've got a couple of sisters and they spoil her a lot... otherwise it doesn't get in my way or anything.
Kate:	So you have some space of your own?
Mrs. Sherwood:	Yeah, yeah, I have a little suite downstairs.

Kate: That's good you can be separated if you want to be. You were looking for a job last time you came in...did you have any luck or...?

Mrs. Sherwood: I tried the post office...but right now my Dad is having trouble with his business...he's trying to get somebody in to manage...so I just go in a couple of days a week to help out with the books. I'll be going to school in January to take a bookkeeping and accounting course.

....

Kate: Who will care for Lindsay while you are at school?

Mrs. Sherwood: One of my sisters...she's already got a little boy and he's in school all day...so all she'll have to do is pick him up after school...so she can watch Lindsay.

Kate was following up information on Lindsay's record when she enquired about Mrs. Sherwood's home situation and her job. The discussion returned to Lindsay's behaviour and her next appointment for immunization. Following the immunization Mrs. Sherwood said. She gets spoiled a lot by her grandparents".

Kate: Is that right? Are they fairly good with her?

Mrs. Sherwood: Oh, yeah! I think at times all babies may be spoiled. I can hardly have a say in what goes, you know. Anytime she cries, "go get her!", but then when I left on holidays it was good. I got her on the schedule I wanted...then when I brought her home it was really different. I just said, "let her cry for a while". They're pretty good but my sisters bring her some kind of junk food every night after supper.

Kate: Do you let her have it, if you don't want her to have it?

Mrs. Sherwood: No. Not if I don't want her to have it. You know sometimes my Mum or my sisters will try to give her a piece of chocolate before supper...and I don't...I don't like it, see, because they done that once before and she doesn't eat as much as she usually does for her supper....So now they ask me, which is a good thing.

Kate:	Did you explain the reasons you don't want her to have/
Mrs. Sherwood:	Oh yeah - but then they sit there and laugh at me and they think, "Oh! Trying to be such a good mother", and just bugging me in a way, but now, they realize and don't do it.
Kate:	It makes it kind of hard and frustrating for you, doesn't it?
Mrs. Sherwood:	It does, yes. At times, you know, I really don't like it, but now they're beginning to understand.
Kate:	That's good. That's important.

At the end of this discussion Kate picked up and responded to Mrs. Sherwood's feelings. She then reinforced the mother's actions saying, "That's good, that's important". She allowed this mother time to express her concerns without superimposing any advice.

In discussing the visit Kate said:

> My concern, a big priority as far as I am concerned, is her situation. She's at home living with her child, with her sisters and with her family. She spent time talking about it's not always so good with her sisters there...and she seemed very concerned with the discipline part of it...how her ideas and the parent's ideas of what is good for the child are different. She seems to have conflict [in doing] what she wants for her baby...her parents interfering...I saw that as a priority. I was concerned with the care of her child while she was at school...her arrangements seemed sort of tentative...she wasn't certain what she would be doing. She is not working right now...she may be getting some wages from her father...but otherwise she is fairly financially dependent on her parents...I wonder whether that has anything to do with her parents telling her what's best for her baby...she may feel a little reluctant to assert herself.

Here again, Kate had to make some assumptions because she did not check on Mrs. Sherwood's financial status. It also seemed that Mrs. Sherwood had a firm arrangement with her sister that she would care for the child, but Kate seemed concerned that this was not the case.

> She [Mrs. Sherwood] did mention things were better now, but I could tell they were hard for her and worse at first. I guess I just wanted to try and emphasize to her the importance of feeling good with what she's doing for the child.

Kate indicated that her acknowledgement of the mother's feelings and her reinforcement of her behaviour were deliberately planned on her part. Once again she went on to indicate her reluctance to question the mothers in areas she regards as sensitive.

> I don't know whether she had a ring on, there's no birth notice here, so I have no way of knowing whether or not she's married. It doesn't say here at all [on the record], I assume she's a single mother...and her age, she's twenty years old. There's no family history...that sometimes give you a clue, "no paternal history available". It just wasn't a comfortable time to ask. Usually how you get at it is, "do you have any help with the baby"...but she's living with her parents. There's nothing on the chart to indicate one way or the other. I'd say for this visit the social information was number one priority to me.

It is interesting to note that with her concern over social history Kate had not observed whether or not Mrs. Sherwood was wearing a ring. She reflected, "It wasn't a comfortable time to ask", and indicated that she prefers to try an indirect route to obtain personal information.

A Feeding Problem

Mrs. McClintock, who appeared to be a very young mother, appeared at Richmond Clinic with her fifteen day old son, Trevor. The moment Kate went out to the waiting area to greet her Mrs. McClintock started to talk and I had to wait for a few minutes before there was a pause in the conversation so I could introduce myself and the study. Mrs. McClintock was upset because Trevor had been suffering from colic.

Kate:	Have you contacted your own doctor?
Mrs. McClintock:	No. You see I live in Drayton Valley. I'm here until the end of the month. I had the baby in the City. I phoned the doctor in town.
Kate:	You did eh? You'll be going back to Drayton Valley?

Mrs. McClintock: Yes, the end of the month...I live common-law with Trevor's father.

Mrs. McClintock clarified the social situation early in the conversation, for her it was not a private matter but merely the way things were in her life.

Kate: Are you staying in this area with some relatives?

Mrs. McClintock: Yes, my Aunt...she drove me over to the clinic. She has had her daughter here.

Kate discovered that she knew the child and some social chat ensued. The discussion switched back to Trevor's colic and his feeding pattern. With a big sigh Mrs. McClintock said:

> He was taking four ounces...(sighs), four days ago he started cutting down, now he's down to three ounces...sometimes three and a half, and when I left the hospital the nurse said "anytime now he should be taking up to six ounces" and he's not.

Kate decided to examine the baby, while Mrs. McClintock undressed Trevor, Kate asked about her labour and found she had a Caesarean Section, as the baby was a breech presentation. Kate asked the client if she was unhappy about having a section. "A little bit upset because I didn't expect it." Kate checked Trevor's hips, explaining what she was doing to Mrs. McClintock and she, in turn, asked, "Is that cradle-cap coming through on his head?" Kate looked at it and suggested perhaps it was soap, "you know, it looks as if you've got soapflakes on there, just try and wash it well". They discussed Trevor's dry skin and Mrs. McClintock said, "I've been using baby oil on that." Mrs. McClintock had relaxed considerably since she first brought the baby into the room and the conversation seemed relaxed and friendly. Kate checked a rash in the diaper area, what mother was using and how well she was washing the area when the diaper was changed. She commented. "That rash could just be from Pampers, you seem to be doing all you should." Kate turned to the researcher and said, "What do you think?" I agreed with her, "It looks like an allergic rash, it's just in the diaper area and not anywhere else." Mrs. Sherwood commented, "His belly button looks real good, doesn't it", and Kate agreed. Kate now returned to feeding.

Kate: So you're finding the baby's feeding schedule very demanding.

Mrs. McClintock: Yeah. (Pause) He's a very fast eater too. He's always getting hiccups after every feeding.

Kate: (still examining the baby). I'll test his eyes right now. What kind of bottles are you using?

Kate followed her own train of thought here and did not pick up Mrs. McClintock's comment about the hiccups, instead she checked the nipples and the speed of milk flow from the bottle. Mrs. McClintock said she had been breast feeding but the baby was "lazy" and "would not work for his feeding". "He was 8 pounds 3 when he was born and he went down to 7.15, so the doctor told me to put him on formula." Mrs. McClintock had been home five days and Kate explained that a change of environment often upsets a baby's routine.

Kate: Did they check his weight out there?

Mrs. McClintock: Yeah, they did.

Kate: How much did they say the baby was?

Mrs. McClintock: (Hands paper with weight on to nurse). Like his hiccups, he gets them pretty badly everytime he eats. Will giving him sugar water help - or just the formula?

This time Kate did respond and said, "I don't think his formula has much to do with his hiccups...I think it's just...are you burping him between his formula?" She did not give the mother an explanation as to why she did not think the formula was related to hiccups but continued to pursue the topic of burping.

Mrs. McClintock:	I think I'm worrying too much.
Kate:	Most mums do with their first. You're a little bit anxious. You're feeling tired yourself...and it's difficult because you're trying to get your health back.
Mrs. McClintock:	(quietly) What else did I have down that scared me?
Kate:	Let's just check the weight and see how it is.

Kate once again responded to a mother's feelings by reassuring her that her reaction is to be expected but did not respond to Mrs. McClintock's next cue. She switched back to the weight only to discover that the baby had lost another nine ounces since discharge, five days before. Looking at the growth chart she said, "he's a bit more in length than weight...so proportionately he's under in weight."

Kate:	He's a little bit lower than normal...how much does he take in a day?
Mrs. McClintock:	As far as milk? He takes...he's got six feedings of four ounces...that's 24 ounces.
Kate:	Six feedings of four ounces.
Mrs. McClintock:	Yeah. He usually takes four ounces...three and a half to four. There'a a couple of odd times he takes five.
Kate:	We'll keep an eye on his weight...will you be able to come back to clinic to get his weight checked again.
Mrs. McClintock:	I'll be here until the end of the month.

When Mrs. McClintock first came in she said, in presenting her initial concern, "he's down to three, three and a half ounces" per feed. Kate did not check on the discrepancy, but planned to recheck the weight in a week. Mrs. McClintock had a prescription for the baby for his colic, the doctor had not seen Trevor but had prescribed medication over the telephone. Kate advised:

> We'll see how he's doing, just keep feeding him his formula and give the medication the doctor prescribed...but only when he seems to need it, not every feed...only if he is gassy and fussy after his feeding...otherwise you forget the medication, because you don't want to be giving him it if he doesn't need it.

Following this advice Kate enquired how Mrs. McClintock was feeling and asked whether her suture line was alright. She then took a family history and when she got to hereditary disease Mrs. McClintock said:

> What's hereditary on the Father's side is...how to explain it to you...I got this information through his sister in law...a piece of muscle blocks the tube...and it's happened to every male in the family that they had to get this tube cleared...it usually happens to the child two weeks after birth...they throw up with pressure...it's called...I forget...but I had to inform my doctor about this.

Kate asked if she had informed her doctor and the mother said that she had. The baby had been restless, so his mother gave him a bottle, she said to the baby, in a quiet voice, "He's choking all the time, what's the matter?" Kate was looking for the feeding guidelines for 0-3 months to give to Mrs. McClintock and missed the mother's cue, "these may not be the same as your doctor has instructed but it gives you some idea...."

When discussing the visit Kate showed that she had noticed the discrepancy in the mother's information:

> Taking every six hours, four ounces of milk, sometimes five, sometimes three...yet she was so very concerned...I wonder if the weight is right...to lose so much weight...like she was in hospital for ten days...she seems to be feeding enough...I think she is just anxious and needs some reassurance....I'll go to the home and follow her up...she seemed kind of nervous too...I think I'd like to see her in her own setting. (14/11/79)

Following this Kate asked, "What was it all the boy babies had - I didn't understand?" I suggested it might be pyloric stenosis. "Oh yes, the description fits - I'll read up on that before I go to see her." There does seem to be areas where Kate still has gaps in her knowledge base, but she is always anxious to find articles and to read when she recognizes a need. In the schools she had a couple of children who had had a myringotomy and she asked the other nurses in clinic whether they had come across anything in the literature. Lois referred her to an article outlining a teaching programme for nurses to use with parents. Several times during the next few weeks I asked about Mrs. McClintock, but without her black book in hand Kate had difficulty keeping her clients straight, "I can't recall who you mean, if I had my book with me I'd look it up...I see so many clients." Many of Kate's clients do have similar problems and when she is visiting she recalls previous interactions with them, however, away from the client she was the least reliable witness amongst the four informants.

A Question of Priorities

Jodi Watt was a one year old brought to clinic by her mother for immunization. She was a thin, pale, redheaded little girl who seemed to be very active. The mother, a twenty-one year old girl, who was obviously pregnant, appeared tired but seemed to enjoy Jodi. Kate asked if Jodi was her first child and Mrs. Watt immediately started to talk about David, her three year old son, who was in the custody of her husband, from whom she was separated.

Kate:	Has that been for long, or...?
Mrs. Watt:	Since July and I haven't visiting rights or nothing see so I'm going to take him to Family Court so I can get some visiting rights, and if I don't get them he's

> going to lose him...because I'm going to fight for custody...he got custody on one condition, that he let me come and visit or let him come and visit me...but he hasn't held to it. (14/11/79)

Jodi was playing on the floor, laughing and gurgling to herself during the conversation. Mrs. Watt glanced at her occasionally, but was content to let her play. Jodi had a fireman's helmet that was much too large for her that she was taking on and off.

Kate: How old is your little boy?

Mrs. Watt: David is three and a half (laughs).

Kate told Mrs. Watt she would like to do a developmental test on Jodi, but Mrs. Watt informed her that Jodi recently had one completed by a university student, who had come out from the family clinic. She seemed proud of the fact that the student had told her, "she's ahead of her age".

Kate: Jodi hasn't had any immunizations?

Mrs. Watt: No! (laughs - sounds uncomfortable).

Kate: You attended clinic a couple of times.

Mrs. Watt: Yes, well, see, I was supposed to bring her back in...when was it January...I was supposed to bring her back for a shot...then she got a cold.,..and ever since then I've been postponing it...plus I wasn't in the city all that time...I stayed with my Aunt in April... so I didn't even bother until right now. I've settled down now, plus I'll have another one on the way to the clinic pretty soon...because I'm six months pregnant right now.

Mrs. Watt recognized the need to bring her children for immunization, unlike many of Kate's clients, who she must try to convince, it simply has not been a priority in the middle of her social upheaval. In relation to the pregnancy Kate asked, "Are you happy about that?" Mrs. Watt responded:

> No...in a way I am and in a way I'm not. It's my boyfriend's - and he was staying with me for a while. Everything was going good and then all of a sudden...he was supposed to be back between the twentieth and thirty-first [of October] and he's not come. He's not hurting me physically but mentally it's hard. He wants this baby as much as I do...he wants to come into the delivery room, problem is when is he going to come - if he is going to come.

Kate did not respond to this, but asked "How old are you?" Then she said, "Are you interested in prenatal classes?" Mrs. Watt replied, "Not particularly", but Kate continued to press the point.

Kate:	Have you ever been?
Mrs. Watt:	Yep, when I was fifteen years old.
Kate:	Did you go to clinic?
Mrs. Watt:	No, um, no - I lived in B.C. and my Aunt was going, see. Since then I've had two kids and can remember pretty well all I have to know.
Kate:	So you don't think you need anymore?
Mrs. Watt:	No. I went with David, I didn't have to go. I remembered everything I had to do....You know, in labour like. I remember all the things that prenatal classes taught you.
Kate:	What do they teach you in prenatal classes - or what did they teach you in the ones in B.C.?
Mrs. Watt:	They were teaching you exercises - how to take care of your health, what to eat, your breathing...and how you're supposed to sleep and pick-up something, the way you're supposed to pick it up.

Kate pursued the topic further as she wanted to find out if the classes offered at Greenfield Clinic offered more information than she had obtained previously as classes differ from agency to agency.

Kate:	Do you think it will help you review a little bit...? Since you've been through the experience before you may get more out of it....They have classes at Greenfield you know...that's not too far, they hold them once a week. (Pause) You don't want to, eh?
Mrs. Watt:	No, I really don't want to.

Kate: Okay.

Mrs. Watt: I'm feeling depressed and I just really don't want to go anywhere I don't have to go. I'm just that way right now...trying to get everything settled down.

Kate: What about...would you be interested in reading some pamphlets or information? We have little booklets we give in prenatal classes...and I could have them dropped off to you...so you have the information to read...if you wanted.

Mrs. Watt seemed receptive to the idea and Kate made a note of the address. In discussing the interview afterwards I asked Kate why she had focussed on prenatal classes.

> Well, the agency wants as many people to come to prenatal classes as possible...and I also wanted to know what she knew about her pregnancy...I wasn't sure that she understood...so I thought if she would come to classes...but she didn't want to...so I thought if she had the pamphlets she might read them. (14/11/79)

At a later interview we were discussing Mrs. Watt, as she had failed to return for Jodi's next immunization. We spoke again of the prenatal classes and Kate said:

> Sometimes I will introduce them because seeing how they view prenatal classes gives me some indication of how she views her pregnancy right now. (22/2/80)

In this instance Mrs. Watt had given a clear indication of how she felt about her pregnancy, so it would appear that Kate saw prenatal classes as an agency priority in this case, and so attempted to make Mrs. Watt see it as a priority for her too. This is compatible with Kate's attempt to motivate them toward actions which will result in the achievement of agency goals. In this instance it may have been that agency goals took priority over some of the mother's needs.

The Missed Cues

Within this visit Kate failed to pick up several cues which might have identified a client's need for nutritional advice. Jodi, was a red-head with very white skin, so while she appeared pale it could possibly be attributed to her natural colouring. She had dark circles under her eyes. In the clinic she appeared to be a very active little girl, Kate remarked on this, "She really is a very active little girl". Mrs Watt replied, "Yes, but she tires quickly." This exchange occurred as a social interlude during a discussion on Jodi's eating patterns. In relation to this Mrs. Watt said, "Oh, she usually has milk and cereal for breakfast, but this morning it was toast and jam, I'd run out." Kate did not pursue the topic of diet in any detail, in contrast to her visit with Mrs. Christopher. However, Mrs. Watt had not raised the topic whereas Mrs. Christopher had done so. Finally, during the immunization, Mrs. Watt remarked, "Jodi, really hates needles since she had blood taken." When Kate left the room to see if there was a pamphlet on prenatal care at the clinic, to save mailing one, I used the opportunity to ask why Jodi had to have blood taken and Mrs. Watt confirmed that the child was being treated for anemia. Kate seemed to have difficulty in assimilating clues unless she had a defined framework. For example, she was adept at picking up verbal and non-verbal cues related to mothering behaviour, but this is an area that she anticipates assessing during a visit. There were indications too that she did not utilize social conversation and maternal asides as a source of data. Thus, despite her concern for identifying and responding to maternal needs she did not always react to the more covert needs of the client.

Negotiating Priorities

When Kate spoke of change of behaviour in clients she said:

> If she [the client] doesn't see this as important then I would rather that she didn't change at all, you know if it's not a priority for her I hope that she wouldn't be changing her behaviour just because someone else says that she has to or that the public health nurse is watching her. I hope she's going to do it because it's important to her and a priority for her and until then I just don't think it's the right time. (22/2/80)

Yet agency concerns about the immunization programme require Kate to follow up many of her mothers who have not brought their babies in to clinic by four months of age for a first immunization. Kate assumed, from her experience, that immunization was not a priority for many of the mothers in her district. So when she had to go out to see them she tried to interest them in other aspects of the clinic.

> Immunization isn't that important to them [the clients]. So if I say something like "immunization starts at two months for your baby", the chances are I'll only get a few of them in there..so I tell them other things. For instance, if the mother is breastfeeding...and they wonder if the baby is getting enough milk I say, "Well, if you come to clinic you'be be able to weigh your baby to find out if in fact your baby is gaining weight." Sometimes I'll go to a Mom and she'll start talking about her other children in kindergarten and maybe I'll mention that we start health records in clinic and these go with the child through school. I went to one Mom the other day and she was all concerned because we weren't going to know what needles the child had because she'd got them at Dr. Bevan's office and we didn't have a record...when I told her about clinic and the health record she was delighted...because she knew if she came the immunizations would not get mixed up. Whatever I can find that seems important to them is the way I try to get them to come to clinic.

An example of the follow-up Kate must do is illustrated by the Desjarlais family. Both the mother and one of her daughters, Rena, had new babies and neither had appeared in clinic to get the baby immunized. Kate explained that it was a multi-problem family, she felt Mrs. Desjarlais was not receptive to the idea of immunization, "she pretends she doesn't hear you and she really does." While Mrs. Desjarlais' English is limited Kate knows from school contacts that her comprehension is adequate.

> That family has so many problems that I wouldn't be at all upset if she never did get the baby immunized until the child is in school, it wouldn't be a big deal to me. What I'm more concerned about is the health of the baby and whether the child gets examined...has he been to a doctor...so that is why I'd like to get her in.

Here Kate supports her belief that in her district agency priorities are not necessarily her priorities, that often concerns are related to the basic physical needs of the children.

> Rena obviously sees immunization as more important than her Mum does...so I would ask Rena if she could bring mother's baby to clinic when she brings her own...I know what the Mum is like...I know I'll never make much progress.

Rena did bring her own baby to clinic, the Wednesday after Kate called her, but was unable to bring her brother. Kate commented on this saying:

> I think sometimes they [the clients in her area] just need a little egging on...they aren't that independent...you have to prod...like they'll come if you phone and remind them.

Kate compares her clients with those in other areas who she believes are conscientious and, "write down the date of the appointment. It's really important to them - so there's no way you have to phone and remind them". She added that while she'd like her clients to come of their own accord, "a lot of times they don't show just because they've forgotten". "They have every intention of coming back, but they just need a little prod to get them there". Kate differentiated between Mrs. Desjarlais, who has no desire to come to clinic, and her other clients, who see a need but do not make the effort to get there. She saw them as dependent, which given the nature of her district, would seem to be a realistic assumption. Given her assumptions, following up these mothers and reminding them that it is time to come to clinic does not violate her belief that client's should only act if they believe the behaviour to be desirable.

Conflict Situations

Kate had constant problems with one group of medical practitioners in her district, Dr. Bevan and Dr. Walters. They immunize all the children who come to their office, "they collect a fee and don't tell the Mum we provide a free service." There are several problems, "they are not up to date, and their nurse is always phoning and saying, 'Kate, what are you doing in clinic', when a child's only had, say one measles shot, and that was a year ago." Then you have to find out if it's live or killed and it takes your time. Another problem is that because they only immunize children within their practice their vaccine gets out of date. Kate sees the doctors as duplicating a service, "that is better for the clients - because we are up to date and do it everyday".

She also had cause to feel that the doctors are not as thorough in their care as she believed they should be, one example of this was the child who was overweight, that she picked up in the school. She is not alone in this belief, a teacher at Snowden, commenting on a child said, "Do you think the Mum would agree to you getting Dr. Chivers to see him...they go to Dr. Bevan and you know what that's like".

On occasions Kate encountered a mother in the clinic where she felt a second opinion was needed.

> You have to suggest very subtly to Mom that this second opinion might be helpful...because they have a lot of faith in their doctor and you don't want to destroy that. (22/2/80)

Mrs. Phillips brought her son, Alan into clinic. (13/2/80) He was four months old and had a rash that had developed some weeks previously. It looked as if it could be an infant eczema and Kate was concerned that it might be a milk allergy, particularly as Mrs. Phillips reported that he regurgitated a lot and was "real sour smelling". She had taken him to Dr. Bevan, who had told her not to worry, just to wash the baby well, put vaseline on and it would clear up.

Mrs. Phillips:	To tell you the truth I'm not satisfied.
Kate:	Have you thought of taking the baby to a pediatrician...a doctor who specializes in babies?
Mrs. Phillips:	Then I'd have to get the doctor to refer me...and I don't like to do that.
Kate:	Did you have a pediatrician see the baby when he was in hospital?
Mrs. Phillips:	Yes...but he said everything was okay...so take him to my own doctor.
Kate:	That did not mean he would not see you again if you had concerns. Who was the doctor?
Mrs. Phillips:	Dr. Gregory.
Kate:	Well, you give his office a call if you want a second opinion, if you are still unhappy after seeing Dr. Bevan, it is your right to see someone else.
Mrs. Phillips:	I think I will call Dr. Gregory and see if I can get him in...my other boys had rashes, but they cleared up...this seems to get worse.

Kate commented that she had to be careful about the advice she gave, because the agency did not like nurses to recommend a particular physician.

> It's easier if they [the clients] have a pediatrician. I do have an idea about which pediatrician is better than another, but I don't

> tell her, because that's not the policy of my employer. When I think the agency's policies are valid, I won't go against them and I think the ethical reasons for that particular regulation are valid. (28/11/79)

However, on the issue of blood pressures she feels the agency is not setting a reasonable policy.

> We started taking blood pressures, but I do not believe in taking blood pressures and not telling the client what it is. I feel if they ask to have their blood pressure taken...it's their right to know what it is. We were told not to tell them and a client came in, asked me what his blood pressure was, I knew I wasn't supposed to give him information, but I told him anyway. (28/11/79)

This decision is compatible with Kate's belief about the rights of the individual and her focus on individual needs. She felt guilty about her decision and talked to the supervisor. "I told her that I refused to take any more blood pressures until that policy was changed." She said, "I don't believe in taking someone's blood pressure and withholding the information from them, and I told her if they came to the clinic I would get someone else to do it." (28/11/79) She explained that she felt she went along with a policy if it was valid, "but if not I won't go along with it...but not without trying to [get it changed]." In relation to suggested medication for temperature elevation Kate said:

> If the mother suggests something I'll go along with it, because she's obviously thought about it, I wouldn't go on "Well, there are others that...." If she hasn't I'd say, "Do you know what your doctor prefers?" and if not suggest she phone him.

With Mrs. Christopher, who brought Andrew in for his second immunization, Kate found she was using Tempera drops and said, "Okay, and you found that satisfactory the first time?" The mother responded affirmatively and Kate said "That's fine then". With Mrs. Watt she just asked the mother "Do you have anything for fever if it is needed?" and when Mrs. Watt said she had, she left it at that. Kate generally seemed able to use the policy as a guide and adapted her advice depending on her assessment of the mother's capability or previous experience.

Group Work with Clients

While Kate was interested in teaching in the schools most of her activity took place in March, which was after the data collection period for this study. She did teach a series of prenatal classes in conjunction with Hazel, the nurse who worked in the adjoining district to her own. Kate remarked, "Most of the families who come to clinic for classes are working class, we have few professionals". Looking at her registration forms this seemed to be true, occupations listed included truck driver, mechanic, shingler, fitter, meat packer, brick layer, glassman, janitor and mechanic's helper. "Because the clients are mainly labourers and tradesmen we try to keep the level fairly simple - they have not read much generally." When Hazel asked how many couples had read about pregnancy, only two out of sixteen raised their hands, so the assessment seemed fair. During the talk Kate was aware of her level of explanation, she spoke of the "afterbirth", showing the clients a picture, rather than the placenta. She described forceps as being "like large salad servers." Hazel picked up on the word "large" and used her hands to show the approximate size. The atmosphere seemed quite relaxed, and toward the end of the session (the first in the series), many of the couples asked questions. When she was talking about expulsion of the afterbirth one mother said, "Kate, is the mother required to help?" Kate responded, "Yes, the doctor may ask you to push down, he may also apply a little pressure to get the placenta, the technical name for the afterbirth, out". In the coffee break both Kate and Hazel circulated, giving the clients time to ask individual questions. (15/11/79)

In January Kate was preparing to teach a city wide "Early Bird" series of prenatal classes. She was anxious about the session as there would be about fifty couples. She was to teach with Ruth:

> Ruth: Last time Carol did the introduction and I did the emotional aspects....There are these transparencies, some I detest, some I pick and choose. Some of them are okay...it gives them a little chuckle and eases the tension when you're talking about something as vague as emotions.
>
> Kate: I'm not sure what I'd do with them....
>
> Ruth: I'm open if you'd feel more comfortable with physical care the first time.
>
> Kate: I think I'd be more comfortable with the physical changes. It's more concrete the first time.

In prenatal classes the nurses work in pairs and both in the classes and in the preparation there is evidence of support and mutual give and take of ideas. Hazel enlarged on Kate's description of forceps when she thought clarification was needed. Ruth picked up Kate's anxiety and responded.

> Kate: Yes, I can do that. I'll be really nervous, but it's good for me to do it. I'm going to be nervous because it is such a big group.
>
> Ruth: Last time I wasn't comfortable with the introduction that's why Carol did that section.
>
> Kate: One reason I don't like large groups is that you don't know who is there. You may have a doctor and then someone who doesn't understand English. You can't know what the needs of the members of the group will be.
>
> Ruth: You have to try and hit the middle of the group. You can't do anything else. We told them to get their papers and pencils out to write down their questions.
>
> Kate: Did you get many?

> Ruth: No, but a few people came up in the break - they were much the same sort of questions we get here [in Greenfield Clinic]. (29/1/80)

Kate said afterwards, "I don't like the idea of such large groups - the agency is doing it because the demand is so heavy, and they say they can't afford smaller groups in each clinic". Her discomfort was in part related to teaching such a large group, in part due to her feeling that with a group of that size, you would not meet individual needs. Again Kate demonstrated her willingness to try something new even when she was apprehensive about the task in hand. After the first session Kate reported, "The teaching was not so bad, but we didn't get many questions and I don't know whether we gave them what they wanted". Her concern for individual needs again comes through in her comments.

Summary

Kate indicated that her primary focus for a visit was in part based on the child's needs and in part by the questions the mother raised. When these were attended to then she would try to establish her priorities as important to the mother. It is obvious that while Kate does attempt to attend to the clients' priorities, she picks up overt cues but appears to miss some covert cues, or those offered in social conversation, thus she is not always successful in meeting the individual's needs. When she introduced some of her own priorities, such as the eight month developmental test, or the need to give the child homo rather than 2 percent milk, she did not always give the client the reason for the recommended action and the client did not always indicate, by her response, any real conviction of the need to follow the suggestions. In evaluating the situation Kate did identify the client's stated needs when she identified her priorities for the visit, this was therefore consistent with her stated beliefs. Because she saw clients in her district as having many social problems she believed information on social and ecocomic status to be important, yet she frequently felt uncomfortable obtaining this information, so did not pursue it even when she felt it might be to the client's advantage. She demonstrated that she was responsive to client's feelings and was supportive of decisions that they made even if they conflicted with suggested agency guidelines, providing there was no evidence of detrimental effects on the child's health. Kate's perception that many of the problems in her area were centered around basic physical needs such as feeding, diaper rash, and cradle cap were supported in the client visits observed. When she encountered situations with which she was unfamiliar, such as the baby with pyloric stenosis, she showed that she did use available resources to increase her knowledge. While she had to prod many of her clients to come to clinic, the fact that she had to help motivate them was not a violation of her beliefs as she felt the client was basically concerned but did not see immunization as a priority on any given day. Generally client priorities took precedence over agency priorities although there was one occasion when Kate pressed an agency priority without obvious justification. In her district the major source of conflict appeared to be with one group of doctors whose level of practice she questions, but she did not have face to face contact with members of this group. There were times when she felt a client needed a second opinion but agency policy and her interpretation of nursing ethics limited intervention to generalized advice and indirect persuasion. She also felt that the doctors charged clients for a service, immunization, that was provided through the clinics, a service which she believed to be superior to that offered by the doctors. She utilized various approaches to encourage the mothers to attend clinic. In her classes she attempted to teach at a level she perceived as appropriate to the group and showed concern for lack of individual contact when she had to teach a large class. Despite her anxiety about teaching a large class she viewed it as a professional challenge and a means of promoting self-growth.

Kate's Perspective of Nursing

Kate's perspective will be discussed in terms of the three dimensions identified by Becker, Geer, and Hughes (1968, Cf. Chapter 3), the individual's definition of the situation, the action or activities engaged in by the individual as a result of their definition and the criteria of judgement used by the individual.

Definition of the Situation

Kate believed that the major purpose of public health was to prevent illness. She saw this as being achieved through organized programmes, such as immunization and screening and through client education. She believed that to be effective the nurse must meet the individual needs of each client and that it was the clients themselves who could identify their priorities. Kate believed that in her district the clients' focus was on basic physical needs, such as feeding, clothing and shelter and that they were not ready to consider long-range concerns such as child safety and immunization. Therefore the nurse had to negotiate with the client to create an acceptance of the need to consider such concerns or priorities. If a client changed her behaviour merely because the nurse suggested she should, but without any real conviction that such change was desirable, Kate then viewed such change as undesirable. For Kate change must stem from the client's own motivation. Kate viewed herself as setting priorities in her own life and felt that she attended and gave her energies to the concerns that she priorized, such as her athletic activities and music. In part she selected public health nursing so she could give priority to her leisure activities along with her work. Thus her definition of her client's situation in part reflected her definition of her own lifestyle. Because Kate believed that she could not do all that was expected of her within given time constraints she valued a co-operative approach to case-finding in the school setting and viewed teachers as a necessary part of the health team. At the same time she believed that the school, and therefore all the people within it, was her client, rather than focussing on the students alone.

Kate felt respect between nurse and client to be essential if nursing intervention was to be successful. Respect was generated by example, that is in the openness with which the nurse approached the client. The area had a transient population and while Kate felt that her role was to be readily available to the client she was concerned about the danger of a client developing a dependent relationship. Kate saw herself as inexperienced and looked for external feedback from clients, colleagues and teachers as reassurance that she was selecting appropriate priorities in her work and that she was giving effective care. Kate saw herself as enthusiastic about her work and felt she devoted her full energies to caring for her clients.

Kate's Nursing Activities

In Kate's work with her clients it was evident that she did attempt to respond to their expressed needs but she appeared to lack the ability to identify the more covert needs of the clients. Her questions tended to deal with the information at a superficial level and she did not perceive alternative cues if she was already preoccupied in pursuing another line of thought. Her schedule was flexible and she set her priorities dependent on individual client's needs rather than being concerned about the time she had available. In the school a great deal of Kate's energies went into maintaining records, a fact she deplored as she felt it took away from nursing activities, such as teaching and home visiting, in relation to school concerns. She spent time educating teachers so they could observe children in the classroom for potential health problems. She also spent time in the schools and was readily available to staff who consulted her on family problems as well as discussing the children about whom they had concerns. This time spent with teachers appeared to have been effective as she did receive referrals of potential health problems in both her schools. With some teachers she did have to establish the fact that her role was not that of a truancy officer, but mainly she saw teacher use of her time as effective. In the schools Kate organized her year around the agency programmes of immunization, visual screening and maturation classes, but her time in school was not inviolate if a crisis occured in her district.

Because of the transient population in her district Kate did have to spend time finding clients. Again she had established a liaison, this time with the managers of the various housing complexes, so that she could more effectively keep track of clients. Many clients did not have telephones, but Kate preferred to make unannounced visits as she felt she was able to assess the situation more accurately if clients did not know she was coming. There was evidence that clients would tidy the house, and in the case of single mothers, hide the boyfriend's clothing, if they knew the nurse was to visit. Kate felt this was due to the fact that they might lose social assistance if the social worker knew they were sharing accommodation. While she believed mutual respect was necessary for trust, she was not always completely honest with clients, particularly if she was uncomfortable in a given situation, such as the hygiene visit. Kate identified the fact that she felt insecure in her role and this was demonstrated by her discomfort at interviewing in the presence of a third party and her reluctance to contact clients when their command of English was questionable. She was the only nurse who was obviously made uncomfortable by the presence of the researcher, a fact which she readily verbalized. Kate was concerned about the low self-esteem of mothers in her area and was careful in her guidance not to criticize actions, such a early introduction of Pablum, even when theoretically she knew it was not advantageous, providing the child was doing well. She identified ways in which she negotiated with clients to get them to bring their children for immunization. She would use the mother's concern with feeding to get the child to clinic so the agency goal of immunization could be met. Her concern for individuals was evident in her work with the schools, in her intervention with the boys on the heavy equipment and in her concern that the Vietnamese family might have been frightened by her first visit. In group situations Kate encouraged questions and was concerned in relation to the large Early Bird classes that individual couples might not get their needs met. Again her own feelings of inadequancy were evident in the planning session, but Kate showed a willingness to try new ventures and had a genuine desire to develop as a nurse, this was evidenced through her remaining in what was to many nurses a frustrating district and was a motivation for her participation in the study.

Criteria of Judgement

In nurse-client visits Kate's primary criteria for evaluating the visit were the priorities that the mother expressed. She felt that this was where she had to place her major focus during the visit. In the clinic she also assessed whether the baby had seen a doctor recently and therefore whether physical assessment was essential at that time. If the child was on the verge of walking she would consider the need of giving anticipatory guidance on household safety. Because of Kate's reluctance to ask questions that she felt to be of a personal nature she did not always secure sufficient data on which to base her evaluations of a situation. Nor were her observations of the non-verbal and social conversation exchanges always adequately used. This meant that while overt problems were dealt with covert problems were not always explored. Priorities also presented a problem for Kate as once she decided on a course of action she did not respond to the clients reaction to her input.

In the schools she had a developed a sound knowledge of the teachers so was able to decide whose word she could accept without checking a child herself and in what situations she needed to intervene. With time constraints she had to set priorities, so always had teacher conferences with the kindergarten and Grade I teachers, as she believed for prevention to be effective you had to get to the problem early. On the other hand she only had conferences with teachers in the senior grades when she felt they were not reliable in their referrals. In working with the children Kate also showed evidence that she set priorities, she did not cross-check the vision of a Grade VIII child because she felt his eyes should be rechecked after six years so her intervention would merely be a duplication of effort. In evaluating the families Kate also used the return of the health records as an indicator of how high a priority health was within the family setting.

When Kate was setting priorities she saw young mothers with new babies as a priority and social worker referrals as needing immediate attention. She would cancel planned activities, such as vision checks, if need be, to accommodate these priorities. Kate believed strongly that change that was not self-motivated was not effective and she was upset about a visit she had made to a mother whose child had poor hygiene. The child now came to school clean but she felt the mother only made the change because the nurse insisted there was a need. She therefore judged the intervention to be unsuccessful because while the child's needs were met she had not met the needs of the mother.

Kate's model of nursing had six major elements: (1) a belief that the goal of public health nursing was prevention of illness; (2) a belief that the nurse should focus on the client's identified priorities; (3) a belief that respect was generated between the client and nurse when openness existed; (4) a belief that the nurse must negotiate agency priorities with the client; (5) a belief that the clients in her area were mainly concerned with physical needs; (6) a belief that co-operation between professionals was essential for preventive health care. Kate's nursing activities and the criteria of judgment she used to evaluate her care are related to these elements. In nurse-client interactions her own skill level often resulted in overt problems being met while more covert problems were not identified. In the schools she had established a working system of teamwork between herself and the teachers on which she could rely. Records and paper work interfered with her concepts of the nurses role in the school using time she believed should be spent in preventive activities. Visits to new mothers were a priority for Kate as she saw early adjustments as critical to prevention of future problems.

CHAPTER 8

LOIS

Introduction

Lois is in her mid thirties, she is widowed with a school-age daughter. She is of medium height, slim and always looks neatly dressed. Lois graduated from a basic baccalaureate programme in nursing. She had worked for thirteen years at the time of the study but most of her experience had been in hospitals, in adult and child psychiatry. She had also been a head nurse for some years. When she moved to Western Canada, two years ago, she had applied for a position as a public health nurse and had been offered the job of infant and pre-school nurse, which she accepted. This differs from the district nurse position in that she was based in the clinic, had no schools and visited families classified as "at-risk" throughout the total area served by the clinic. Lois became a public health nurse for two reasons, one professional and one personal:

> Back when I was a student I worked a bit with the V.O.N. (Victorian Order of Nurses) - and a little bit with the Public Health Nurses - I didn't have a lot of experience but it seemed like interesting work. Then when I graduated I went into psychiatry, I think that influenced me quite a bit. There we were working with children with problems, and I found it frustrating, it seemed very hard to make inroads at all in really helping them...I felt you had to get to people sooner even than three years of age, to really help. The other really important aspect with me, having a young daughter, is that the regular hours are a great help to me...and that was certainly an influencing factor. (19/10/79)

Lois also sees the city health agency in which she works as "progressive" and "very open to input from staff when planning their programmes." She feels, "they're very good at providing inservice and give excellent orientation...so that it really seems to be an excellent place to work."

Personal Characteristics

Lois, in describing herself, said, "I'll describe how I think most people see me...and probably the way I see myself too." She saw herself as being, "fairly quiet and reserved to a certain degree", but, "generally I will ask questions and clarify points which I feel are not clear or if I think there's another side of things to investigate." So while Lois see herself as reserved she does not see this as an inhibition to her professional effectiveness. She goes on to say:

> Generally I am fairly easy to get along with as far as dealing with clients...I feel I'm not - abrasive, fairly accepting of what comes up. (28/11/79)

Lois thinks that she does not find it easy to get to know people, "really well" and that, "other people don't find it easy to get to know me well, partly because I am so quiet." She thinks that as a nurse this is, "a little bit of a handicap because you're always having to meet with people, particularly when you are going into their homes...." Lois feels it would be easier if she was more outgoing, "a person who easily meets and gets to know new people", as she believes that making the first contact with a client is, "initially a little harder for me", but after she has had repeated contact with clients, "it's no longer a problem".

As a person Lois see herself as, "fairly organized" but, "it's probably not my top quality." She feels she may, "tend to fall down on details", such as all the paperwork she has to do as the infant and pre-school nurse. In her job Lois finds it is, "sometimes hard to stick to priorities and make sure you are getting the most important things accomplished first."

Public Health Nursing

For Lois, when she speaks of public health nursing, "I think the prevention end of things is where we ought to be", which she explains is, "helping to prevent disease". Promotion is, "more geared to continuing healthful activities." Lois' priority in the job is, "finding the at-risk family and preventing crises", but she adds, "this is part of my job as infant and pre-school nurse, if I was in the district it might be different."

> I think probably teaching the problem families is critical...either those we pick up through home visits, or through their attending the clinics...and the problems, becoming alert to them...and following the high risk, seeing they [the children] are developing and if not getting them referred. (19/10/79)

In part Lois sees her priorities as based on her experience in child psychiatry, in part by the agency priorities in her job. What she would like to see is more group teaching for some of her clients.

> We tried this mothers' group one morning in the month....We tried to run a teaching programme where we'd discuss nutrition or child development, safety, various topics like that. Something we need to look at more closely is how you can manage to get these people to come out. (19/10/79)

Lois reflected that in part some of the difficulty in motivating the clients might have been the large number of single mothers she saw.

> I think one of my concerns in this area [Greenfield Clinic] is the high number of single mothers...about 20% of the mothers we see in this area...are single. That's just based on the statistics from the birth notices, there seem to be quite a few that become single later through separation, or who are virtually single because the husbands work out of town and are scarcely around. (19/10/79)

Lois felt that the situation created a lot of isolation for new mothers and that there was potential for child abuse with the mothers under a lot of stress. She felt that it was ~~of~~ high priority "to provide assistance to these girls."

Lois brings to nursing, "a good background knowledge in the social sciences" and feels, "It's the social side of things which interest me." She feels her basic educational program, "put quite a bit of emphasis on that". She thinks she has, "strength in assessing and dealing with the social side of things." It was not just her basic education that had given her this but also, "the experience that I have had in psychiatric nursing and child psychiatry in particular". Lois also finds, "having a child of my own does give me a lot of insight into just how it feels to be a mother." She feels managing a child has increased her sensitivity to how other mothers feel.

> Having lost my husband I think I feel more comfortable than a lot of people on the bereavement visit because I feel I have a lot of insight into what the whole thing is like....Meeting up with so many single parents, I've experienced that whole way of life...and probably have some extra insights into that too. (28/11/79)

When she worked in the hospital Lois felt that often she was not in a position to go ahead and plan "with the patient" because, "I had to involve so many other people and whatever I would do would be completely undone." She saw public health nursing as enabling her to be more independent, "you can go ahead and do you own thing." Frustration in the community came from the fact that, "you are trying to get people to change...but in many instances there are so many factors affecting the way they behave, you have no control over it."

I asked Lois if she differentiated between the terms, "patient" and "client". She said she thought she tended to use them interchangeably.

> I think "patient" connotes they need treatment perhaps, but I think often if you've been working in a hospital setting you get used to the term and use it for everyone you deal with as a nurse....A "client" is....someone who is already healthy and you're not treating for anything. (25/2/80)

Lois often did not use either term but referred to "persons" or "people" as she described her work. In this respect she was unique among the four informants.

One thing Lois really liked about public health nursing was, "working with healthy people", she saw it as "a pleasant type of work, for the most part people are healthy, happy and enjoying their babies." She admitted, "there's certainly a mixture" but Lois felt, "You can't help enjoy the mothers enjoying their babies."

> I enjoyed my own baby and this is a nice way of having lots of babies without having to get up at night with them. I think this is a very personal thing, I really do get a lot of pleasure from just the babies themselves. (19/10/79)

Lois has the advantage in her job of working at something she sees herself as enjoying. She also gets satisfaction from helping mothers who have problems.

> I think there's satisfaction too with young mothers who are having difficulty coping. Often it's either a transient kind of thing or something where a few interventions from the nurse can make a difference...it's not a chronic problem...so you can quickly feel you're doing something. (19/10/79)

Here Lois saw a constrast between her previous work in psychiatric nursing and intervention in a crisis with a potentially well mother and child.

> Just supporting a person that's experiencing some post partum blues...giving her the chance to talk and the bit of support you can give them...that seems to make a difference. (19/10/79)

Lois' biggest frustration in her job was her feeling that the paperwork involved in the at-risk family follow-up was excessive. She felt sure that there must be, "a lot better ways of following these families", than checking through the records every month.

> I can see the value in it to a certain extent, that a lot of these people if you didn't follow them would not continue coming...a lot of them seem to appreciate that someone cares enough to be following... but I'm not sure that the at-risk categories that we have, really have a lot of pay-off in following them the way we do. (19/10/79)

Lois found that the high mobility of families also added to her work load as she constantly had to try to track down their new address. She found it was difficult to make an effective intervention with many families.

> Like young single mums who have had so little good in their lives themselves, that it's really very hard to feel you can make a difference and change them into good mothers. (19/10/79)

She wondered if the agency priorities were in the right place, (for example, should the effort be on prevention of pregnancy) and whether effective sex education in the schools should not be a more important community goal.

> But then that may not really make that much difference. I think it really has a lot to do with the many factors in society right now... but I think too that not enough is being done to help these mothers look at their reality and what it means to keep their baby versus surrendering. (19/10/79)

Another of her interests, outside the agency, was teaching prospective adoptive parents. She contrasted these parents to the single mothers.

> They're all so keen and enthusiastic, so looking forward to getting their babies and it just seems insane that there are these potentially excellent parents...waiting empty handed, when there are these young girls struggling away, neglecting and abusing their children.

Despite her feeling that single mothers should receive more advice, Lois is very aware of the client's right to make their own decisions:

> I think it is really quite important that you respect that they [the clients] have a right to manage their own lives and that our role isn't to tell them what to do but just to give them a little more information in areas in which we have expertise so that they can make more informed decisions for themselves.... (28/11/79)

Lois feels too that it is important for her, as a nurse, to have credibility in the clients' eyes, "so they feel what we are saying is something worth listening to."

Summary

Through the process of self-indication Lois defines her perspective of nursing. This perspective is centered on her belief that the goal of community health nursing is prevention of illness. Lois believes it important to identify families where there is a potential for crisis and intervene before serious breakdown occurs. In part because of her job, and in part because of her own life experience, she sees young single mothers as a particularly vulnerable group and wonders whether better counselling and sex education would be beneficial in preventing unplanned pregnancies. She also thinks that single mothers may not receive realistic guidance on the stresses of rearing a child single handed. So while Lois is committed to case finding of at risk families and intervening when appropriate, she is frustrated because earlier intervention has not occurred. However, her biggest frustration seems to be with the amount of clerical work the job involves. She sees her basic educational programme, her life and work experience, and continued inservice as providing her with the knowledge to function effectively as a nurse. Lois also views herself as able to make independent judgements in working with her clients.

In order to understand how Lois' perspective guides her actions it is necessary to examine the context within which her nursing takes place.

Common Events in a Working Week

Lois explained that, because of her job, she spent more time in clinic that the other nurses. She saw her mornings as spent mainly on paper work, this was because she was responsible for co-ordinating the infant and pre-school activities in the clinic.

> At the start of the day I will review the health records of the children who were in the day before...and flag them if there is a problem...I can then review them later and make sure the problem is being followed. If there seems to be a need for follow-up, like a home-visit for a district nurse, or contact with a physician or a social worker...then I'll proceed with that. (19/10/79)

Lois feels that it is hard for nurses in the clinic who only see the family one time, to ensure that follow-up is carried out, this is why she takes the responsibility.

> I find that it is interesting because I do see families repeatedly or follow them through their health records even if I haven't seen them that week.

Lois is also responsible for screening all birth notices that come into the clinic. She codes them for any history that would indicate that the child, or the family, might be at risk, takes the ones she will visit and distributes the others to the appropriate district nurse. After the nurses have made a home visit the birth notices are returned to Lois, who checks to see if further "at-risk" factors have been identified during the visit. She then decides whether the family needs to be seen again. Once a month she must pull out the records on all children due to be followed-up that month, check to see if they have been to clinic and if not, contact the family by telephone or send them a letter.

Throughout the morning she receives the telephone calls that come into clinic, "concerns like, their child has chicken pox, what should they do?" Lois says, "not major problems...just the common problems that come up and they don't know what to do." She also has calls from mothers who want the district nurse to come out, social worker making referrals or other health departments or clinics wanting records. She added, "babies particularly, I don't have much to do with other calls, although I do take calls for adult immunization, travel particularly if no-one else is here."

On some mornings Lois makes home visits.

> The families I see are the categories 1, 2, 3 in the at-risk categories, so that any premature babies, or any who have been in intensive care units, or any multiple births, I make visits to those children. (19/10/79)

If there is a need for more than the initial visit Lois will continue to follow the family herself. Also, as part of her job, she goes to one of the hospitals to give a talk about the clinic services but, "that has become less and less satisfactory as we are having such a poor turnout of mothers." The maternity units are contacted the morning of the visit and are reminded that the nurse will be at the hospital

Table 8-3

Activities in Lois' Working Week Recorded by the Observer for the Periods 26-30 November, 1979 and 11-15 February, 1980

26 - 30 November, 1979

Days of the Week	Hours of the Day 8:30	9	10	11	12	1	2	3	4:30	Evening
Monday	Central Office		Infant & Pre-School Committee		Lunch		Clinic/Greenfield			
Tuesday	District meeting				Lunch		Home Visits			
Wednesday	Clinic/Birth Notices Review - Nurses Notes				Lunch		Clinic/Greenfield			
Thursday	City Inservice				Lunch		Clinic/Greenfield			
Friday	Clinic/Records Telephone Messages				Lunch		Clinic/Greenfield			

11 - 15 February, 1980

Days of the Week	Hours of the Day 8:30	9	10	11	12	1	2	3	4:30	Evening
Monday	Clinic/Baby Notices Check High Risk Families				Lunch		Home Visits			
Tuesday	District Meeting				Lunch		Clinic/Greenfield			
Wednesday	Orientate New Nurse				Lunch		Home Visits with new nurse			
Thursday	School/Records				Lunch		Clinic B.Sc.N. Student Orientation			
Friday	V.A.P.*				Lunch		V.A.P.*			

* City Inservice, Values, Attitudes and Practice.

> I think the nurses [in the hospital] don't think it's a priority and just don't make an effort to encourage the mothers to attend the talk.

Once a month Lois attends a meeting with the infant and preschool nurses from all the clinics in the City. Dr. Short, the medical consultant for the infant and preschool programme, attends the meeting, as does the nursing consultant. The current situation in each clinic is discussed, "For example our attendance is down, is this happening in other clinics", and the nurses are kept up to date on trends and issues in the age group for which they are responsible.

In the afternoon Lois is mainly in clinic, with the odd afternoon out to do home visits, "if I have a backlog." She is also active in prenatal classes, in her turn, and in the orientation of new staff. When Carol moved to Redfield Clinic Lois was to take over her district, but due to a delay in appointing a new infant pre-school nurse she was not able to relinquish her position until mid-February. The second week I recorded her activities reflects this changeover. The recorded activities in the first week support her own description of what occurs in a typical work week (Table 8.3). In common with most of the nurses she overlooked the Tuesday district meeting, which was a "given" for each nurse, in that they were expected to attend. Lois was not attending the total V.A.P. series at this time but was making-up a session she had missed. The orientation for nursing students was provided at the onset of a six week field experience, Lois was orientating the students to the families they would be following during their time at the clinic.

Home Visits

As Lois did not have a district, but did home visits throughout the area covered by Greenfield Clinic, she had a much wider mix of families. She might visit in Carol's district, then Kate's welfare ghetto or Ruth's middle class district. Her expectations of clients were more geared to their problems therefore, than to an expectation of their social and cultural background. The priorities of her position as infant-preschool nurse, that she visit high-risk children and families, reinforced this perspective. Her home visits, were classified by the purpose of the visit, she did not go on a post-partum visit but, "a visit to a mother who had a pre-term baby who was in the intensive care unit." Her clients were preselected because a primary problem had already been identified. Despite this Lois felt some apprehension when she made an initial visit.

> I do find it difficult when you're moving in on someone else's territory when you don't know whether they're interested in having you there or not. If they come to clinic you know they are interested in having the services you offer...after the first visit too, when you have met the people previously, some sort of rapport is established. (28/11/79)

In this case, before going to the home, Lois would recheck the birth notice, or her previous notes, to focus herself on the purpose of the visit. Whenever possible she made appointments to visit, but sometimes the client did not have a telephone number that could be traced, so then visits were made unannounced. She also went to apartments to check to see if the client's name still appeared on the mail box, if it did she would ring the bell and if there was no reply, would follow-up the visit with a letter when she returned to clinic. If the name had changed it was then assumed that the client had moved and that contact had been lost. The other reason for making unnannounced visits was that if she had tried several houses and had found no-one at home and there was a family in the area she had seen previously, rather than waste a trip, she would drop by the home. Unlike Kate, Lois preferred to contact clients prior to visiting when she could.

A Young Mother with a Small Baby

Lois explained that she was visiting Lucille Moreau, because she had had a small baby that had been in the intensive care nursery following birth. From the birth notice it appeared that she was a single mother, she was also only eighteen years old:

> The number of single mothers with babies creates a distinct frustration for me. We handle them as individuals and counsel them...but looking at it on a more global level and the great numbers there are, I feel frustrated....[There is no money] to get involved with things like sex education...there's not enough day care for these mothers who have to work...it frustrates me that this wealthy province won't afford to look after it's children properly. (28/11/79)

Frequently when we were visiting single mothers Lois expressed similar feelings. She could help mothers initially but where were the support services in the community at large? I asked her what criteria she used to evaluate the mother's level of functioning when she visited an "at risk" family.

> Well, all routine things relating to baby care, feeding, skin care and so on. If there are any extra things like the baby being on medication, just to check she's carrying through, and then the family support - does she have other people to turn to - if not we can get a homemaker if needed. Also I check on her own health - how she is physically and mentally coping with the situation. (25/2/80)

Lois used the same general criteria to assess the situation that other nurses used on regular post partum visits, but she anticipated problems, whereas the other nurses tended to assume that, other than providing advice on feeding, all will be well.

Lucille lived with her parents in a well kept brick house, situated in an established neighbourhood. Lucille was obviously expecting us, she came to the door when the bell rang, Lois introduced herself and reminded her that I was the nurse-researcher she had said she would bring with her. The client responded, "I've got nothing to say that's private". She showed us where to hang our coats. The house was tidy, adequately furnished and there were ornaments and pictures of the family members, including the new baby, decorating the walls and mantlepiece. Lucille said, "She's asleep, but I'll get her", and went to fetch her daughter.

Developing a Client Profile

Lois: How are you feeling?

Lucille: Tired (laughs)

Lois: When did the baby come home?

Lucille: Last Thursday. I was so glad to have her home. They had kept her in because she was so small. I went up everyday to see her, but I wanted to get her home.

Lois: How often is she feeding?

Lucille: Every four hours - they told me not to leave her longer than that but to wake her.

Lois: She's on Similac?

Lucille: Yes, the stuff you make from the can - but it's sure expensive.

Lois picked up Lucille's remark about the expense and enquired whether she had a social worker. She suggested she should talk to her if the expense of the Similac was too great, but Lucille said that she could manage, but "it makes a big hole in my budget". Lois returned to the baby's feeding and the amount she was taking.

Lucille: Three to four ounces - she really takes it well but lately she has been crying afer her feeds - I think she's colicky. My Mum got some gripe-water and it seemed to work.

Lois: You're not giving her that all the time?

Lucille: Oh no! Just after she cries and won't settle. My Mum's very helpful...she helps with the bath and answers questions.

Lois: But you care for the baby?

Lucille: Oh yes, she's my responsibility.

Lucille went on to tell Lois that her father and brothers spoil the baby. The baby sleeps in her room downstairs, so does not disturb the rest of the household at night. Lois did not have to work very hard to gather information as Lucille seemed eager to talk to someone.

Lois: It sounds as if your family accept her.

Lucille: Yes, at first my mother wanted me to have an abortion, but I said "No". It was my flesh and blood. Then she suggested adoption, but by then I knew it was a double "No". She gradually got used to the idea and now she spoils her.

Lucille went on to explain that she was still friends with the father and that the social worker was trying to get some support for the baby from him. She herself had finished Grade XII in May, so had not worked, she had stayed at home to look after her little brother all summer.

> Being at home is boring. If I can find a babysitter to leave her with I want to go back to work in January. Maybe part-time like at Woodwards or in one of the stores close by here.

Lucille wanted to get an apartment of her own when she had some money because, once the baby was too big for a crib, "there's no room for a bed - so we'll have to move."

> I want to open an account for her with my Family Allowance cheques - my Mum did that for us. But my Mum says the first few I'll have to use until I get settled.

Lucille paid her mother $100.00 a month for her board, which left her $37.00 and, "The baby's money, which is for formula and diapers and things". A shower, given by her friends, had provided her with clothes, "but they're all too big - I hope she grows soon". Lois checked out that Lucille had had a normal labour and post partum period. When she asked about birth control Lucille replied:

> I don't want another one at this point. I'm not loose living or anything - this just happened, but I want to take precautions in case.

A discussion on birth control methods followed and Lois pointed out that the pill must be taken faithfully each day. Lucille responded:

> Well, I remembered my iron pills alright. I had them in the bathroom, so it was there when I got up I always needed to rush to the toilet in the morning, I had to go first thing - so I think I'll remember okay.

The baby started to complain and Lucille picked her up, held her close and patted her bottom. "She seems to settle if I pat her bottom - but I'm afraid if she's held too much she'll get spoiled." She went on to explain that she feels her mother spoiled her youngest brother and that, at nine, he is still spoiled. She explained that when she had to look after him they fought all the time. Lois discussed the notion of spoiling versus meeting the needs of a new baby, then explained the function of the clinic and gave Lucille some instructions on immunization.

> She's nearly two months old, when we normally start immunization, but as she is so small will you check with your doctor to find out what he recommends? In the meantime if you have any questions I am in the clinic most days (gives Lucille a card). The morning is usually the best as I may be with other Mums in clinic in the afternoon.

Lucille responded by saying, "At the moment everything is okay, but you never know."

When Lois looked back on the visit she felt that Lucille vacillated between a mature approach and being a teenager, "which is normal behaviour for her age." She cited her boredom in the house and her fights with her brother as evidence of this. She also saw her as naive about finances, "she obviously budgets - but probably has no idea of what living alone would cost."

> She's still at the rose-coloured glasses, everything is fine, stage. The reality of the situation hasn't hit her yet. She seems to have parental support, but not support from the father. The baby seems fine and is obviously filling out, but she may need to be encouraged to feed her more often.

After a pause a sudden thought struck Lois, "I didn't get the baby's name - did she use it?" I said I did not think so.

> No - now I come to think of it she said "she" all the time. Normally that would concern me, but her handling was gentle and her eye contact good. I'll check back with her to see what [her doctor] said about the immunization - she may still need support in a week or so.

This interview demonstrates how Lois develops a profile of the client and uses it to assess the level of family functioning. She is concerned that the young mother has not yet grasped the reality of the situation, and indicates why she feels this to be the case. She shows evidence that the criteria she uses to assess the situation are those that she identified as indicators of family function. In January Lucille was still living at home, had no job and was beginning to show signs of frustration that she was tied down by the baby. (Clinic notes, 17/1/80)

An Early Crisis

In speaking of the type of clients she saw, Lois had mentioned mothers who telephoned the clinic with a crisis early in the post partum period. She described a client, Nancy Burton, who seemed to typify the sort of crisis she had implied.

> This mother called on the phone, she was just home with a new baby and I think she was in tears before the end of the call. She just was experiencing post partum blues and it was a real cry for help. (19/10/79)

Lois went out that afternoon to visit Mrs. Burton, who she saw as articulate, verbal and easy to talk with. Because she was open at expressing her feelings she was, "quite easy to try and help." Lois visited her three times, the initial visit, three days later, and then the end of the following week. She saw her function as "mainly giving her a chance to talk about what she was experiencing".

> I think I helped her sort out what her priorities were and to see the fact that she really was setting high standards for herself and expecting she could keep her house running perfectly and be cooking gorgeous meals for her husband, be meeting all his needs, trying to be the perfect little mother, when she had had a caesarian section and was still recovering from it.

Lois felt Mrs. Burton was very inexperienced with babies and simply did not know what to expect, the baby was staying awake longer than she thought she should and she did not know how to cope with it all.

> Really she just needed some reassurance, because she was so verbal she seemed to benefit from being able to talk and sort out a few things for herself with a little help....When I see her in clinic she always seems pleased to see me, so I feel I was able to help her.

Lois commented that really the initial period, "when hormones and everything else were working against her", was the difficult time. Once that was past Mrs. Burton was, "just fine", a "knowledgeable and capable girl." Lois laughed, "Sometimes they're the ones who get into trouble, too much thinking." Mrs. Burton supports Lois' belief that often, in a crisis, the nurse's role is to listen and offer support, this in itself is enough to resolve the crisis if the mother has the basic coping skills. She expressed her feelings of satisfaction that she was able to help this mother and that resolution of the problem occurred in a relatively short time.

A Multi-problem Situation

Lois felt that a lot of the difficulty with young teenage mothers was their low self-esteem, and the fact that, "you can't heal sixteen or seventeen years of negative experience and help them [clients] be effective mothers." In November Lois took me with her when she went to visit Alexa, a young Metis girl, who, "lived in sixteen foster homes in her seventeen years". Currently she was living with the Daniels family, "when she had the baby she was going to relinquish her, but Mrs. Daniels persuaded her not to give the child up for adoption." Lois felt that now, "Alexa is having an awful time making a decision."

Alexa had been visited by Lois because her daughter, Tina, had been in the neonatal intensive care unit with an infection. The social worker at the hospital had called Lois and asked her to assess the home situation.

> She asked me to call her back after I made the first visit and assessed the situation. I got the sort of feeling that [Alexa] was being used by Mrs. Daniels and it turned out the social worker felt the same way.

Lois felt that Alexa was extremely talkative for a native girl but that she had only just, after six weeks, begun to win her confidence. She felt Alexa did not trust social workers too much, "after all those foster homes", so she felt her own contact to be important. She told me of Alexa's history, which was in part, the basis of some of her concern:

> When she went into labour her membranes ruptured early, Mrs. Daniels was away and she was left with the four children. She had no one to

> turn to, so by the time she got to hospital, she had an infection and the baby did too, but she seems okay now. (26/11/79)

Although Lois had arranged to visit on this particular afternoon Alexa was out when we arrived. Afterwards Lois said Mrs. Daniels had gone shopping and wanted Alexa along to help. After this attempt to visit, Alexa indicated she was fine and no longer needed any help, so the home visits ended. Lois was not perturbed at the time because, "she was handling the baby well, her eye contact was good and she seemed to have bonded well". (4/12/79) In February Alexa turned up at clinic and her visit with Ruth is described in Chapter 6, as is her subsequent disappearance. On the day of the visit Alexa's mothering behaviours, as observed by Ruth, supported Lois' assessment of the situation. Lois commented on Alexa's supposed relinquishment of Tina as she tried to put a picture together of what happened after the clinic visit.

> I think it was probably more the people around her that resulted in the baby being given up. My imagination of what happened is that she had a fight with this Diane [who she had moved in with after trouble with the Daniels], that she went back to the Daniels family...and had wanted them to help her out....they had had enough of her changing her mind...and they took out guardianship of the baby. (25/2/80)

When Lois eventually made contact with Mrs. Daniels, she reported that she had adopted the child. Lois was not convinced that this was true, but "I have not been able to contact a social worker who knows." She laughed and added, "To me it's a sort of mystery which I would have loved to have sorted out". Lois wondered whether she could have made a more constructive intervention with Alexa in the early post partum weeks.

> I think, you know, with her history of so many foster homes and such a damaging kind of childhood...there's a sort of self-destructive behaviour that comes out. While a lot of the [mothering] things I saw were so positive, there's the risk that that is what she would turn round and destroy. Really, I'm just guessing...but it sounds as if something would go wrong in her relationship in the foster homes, and probably she did the same thing with the Daniels. I really felt

> there was a lot of potential, but how reachable it was - although for a while it looked as if I could help - but with her history, I would guess, that the chances of her really being able to change would not be that good. (22/2/80)

Alexa represents one of Lois' concerns, that prevention has to start back in the social system. Lois role initially was to check on the baby's progress, she gave help with feeding, but otherwise felt things were satisfactory. Lois was able to help Alexa with early mothering tasks but was unable to intervene in relation to long term problems. She had difficulty contacting the social worker, so was unable to verify information she was given. Alexa's interaction with Tina, followed by her subsequent relinquishment of the child were incompatible with normally anticipated behavior and Lois was only able to hazard some guesses as to the factors that ultimately influenced this situation. She was left wondering whether she could have changed the course of events, or whether, given Alexa's history, that would have been either possible or desirable.

A Family with a Newborn Handicapped Child

Lois had attempted to call on Mrs. Singer, who had recently taken her son home from the neonatal unit, but she was not at home. She decided that as we were close to Mrs. Schwerkov's apartment she would call to see how she was. As we were going in she explained:

> Mrs. Schwerkov had a baby born with a meningomyelocele, she was managing well but was very apprehensive about the whole thing. The baby had a shunt, into her stomach apparently, and had very watery stools, the diaper was soaked right up the back. They took her to the hospital, where the doctor put a waterproof dressing on, to check there was no leakage from the wound, but it was well healed. (27/11/79)

Mrs. Schwerkov had good family support, in Lois' opinion, from both sets of grandparents. "Her Mum came over to help her with the bath and her Dad drove her to the doctor." Because she seemed to have a high anxiety level the first visit, Lois decided to call again. Lois buzzed and identified herself over the intercom, Mrs. Schwerkov answered the apartment door saying, "Do come in, the baby is just settled." Lois asked how things had been going and Mrs. Schwerkov responded, "I can bath her now without anyone coming over." Lois asked if the grandparents were still coming over daily and found that, while they were still readily available if needed, they were now coming less frequently. Mrs. Schwerkov told Lois she had had the baby to the hospital.

> We had a terrible night Sunday, she cried and cried...she was up from half past one to half past five. We phoned the doctor and he said to bring her to Emergency - but she was alright. I was scared the shunt was blocked, because they said if she was irritable and cried constantly it could be a sign, but it was working fine. He said it was colic, so I got some gripe water and yesterday she was okay and today [Tuesday] she's okay too.

Lisa cried and her mother went to her immediately, she came back to report that she was not wet. "I have to change her at once otherwise her skin gets so sore." Mrs. Schwerkov remarked how tired she was and Lois replied, "I can understand that, a twenty-four hour a day responsibility is tiring." Lois and the mother appeared to be mutually at ease in the situation. The information exchange was more like an informal conversation than a formal attempt to gather data. Lois asked few questions as Mrs. Schwerkov volunteered most of the needed information.

> She had a really sore bum, it had blisters but the doctor said Zincofax, but that made it worse. Washing well with soap and water and then cornstarch seems to do the trick. The blisters have gone but I try and change her as soon as she cries and not leave her wet at all in the daytime.

Lois checked on some problems identified previously, and checked on the advice given by the doctor when the family were last in the office. The mother proved to be a reliable informant and could recall what she had been told. She commented:

> When we were in the office he tested her legs and they moved right down to the ankle, her feet don't move too well, but he says that doesn't matter too much - she may have to wear a brace to her knees but he thinks she will walk...they want to put her leg in a cast but he wanted to wait until her bottom healed and the rash cleared.

Lois asked if she knew why the cast was to be applied and Mrs. Schwerkov said the doctor had said he would tell her the next visit and she seemed satisfied with this. Mrs. Schwerkov said she was giving Lisa Pablum and Lois immediately asked if the doctor had recommended this, on Pinding that he had done so, she did not press it further. When Mrs. Schwerkov went to change Lisa, she appeared very adept in her handling of the baby. The buttocks still looked extremely sore but the mother reported they were greatly improved over the previous week.

Lois:	This constant changing must make a lot of washing for you.
Mrs. Schwerkov:	I've got a load in now - but as long as her bottom gets better I can manage.

Mrs. Schwerkov said she had to take Lisa to the doctor the next week, the last time her husband had taken time off from his job, however, the last visit had only taken thirty minutes, "so he doesn't think it worth losing a half-day when my Dad will take me." Lois, suggested Mrs. Schwerkov ask the doctor about immunization. "Yes, it's nearly time to start isn't it? I'll ask him next week."

As we were leaving Mrs. Schwerkov said, "I still get nervous and wonder whether I am doing the right thing." Lois responded:

> I can't think of anything more to suggest - the rash is improving - the feeding is fine and she has certainly filled out since I last saw her. I'll call again - but I hope to see you in clinic if the doctor says it is okay.

Here Lois picked up the client's concern and offered her support. She reinforced the positive things that were happening as a result of Mrs. Schwerkov's care. When Lois looked back on the visit she felt that the mother was managing well, that she seemed able to find appropriate help when she needed it and "certainly her support systems are good." She was somewhat concerned about Lisa's buttocks but felt that if the mother said they were better her judgement was realistic. Lois thought the long term prognosis for Lisa sounded better than at first.

> I'll keep in touch a bit longer, if I was really busy I would probably not visit anymore - but she is still a bit apprehensive, and I have the time.

There is evidence here that time constraints are a factor in setting priorities for Lois too, although without the schools, she does not appear to feel the same pressure as some of the district nurses. Although there was adequate family support, Lois felt Mrs. Schwerkov's anxiety would be best allayed by continued professional input and so decided to continue to follow her. Within a few weeks the baby did come to clinic and received her first immunization and Lois felt that while the mother would continue to need some support she had adapted to the specialized needs of her daughter. (14/1/80)

A Family with an Older Handicapped Child

Michael was a four year old boy, the son of older parents, who was attending preschool at the Glenrose. He had some visual difficulty and showed poor eye-hand coordination. Michael's home was on a tree-lined street, the house was older, two storied, tidy, but in need of a coat of paint. When Lois came to visit the family both father and mother were present but Michael had not yet returned from school. The Glenrose Hospital uses the district nurses to make home visits when required and they, in turn, receive progress reports on the child, which are placed on the child's health record. The nurses appear to have more information on these children than on most of the families they are required to visit on referral. Lois had explained more about the family as we drove over to visit:

> Michael had anoxia at birth and had a cerebral bleed that was never investigated. When you watch him move he looks a bit clumsy and lacks fine motor skills, he also has a bad squint. (28/11/79)

When we arrived the father invited us in and offered us a cup of coffee, which Lois declined. She said she had come to enquire how Michael was doing with his glasses. The father said he thought the prescription was wrong, that when Michael wore his glasses he tilted his head and said he got a headache. The father said, "I don't think the eye doctor prescribed the right thing." He said he himself had visual problems and knew they, "weren't right". Lois asked him if he had thought of taking Michael for a second opinion and the father said maybe he would take him to his own doctor. The parents both went on to say how much Michael liked school, but they might be moving to Calgary and the school would not take him the next term and wanted him placed in a local preschool. Everytime Lois asked if they had explored the local preschools the parents said they might be moving. After the visit Lois said she felt very dissatisfied, "the father has a reputation for being difficult, the Glenrose report says this". She felt the father was talkative but was not sure how reliable his information had been. Michael came in as we were leaving and clung to his mother. The father tried to persuade him to come to the shops, but he said, "I'm too tired". In the few minutes Lois observed him, he whined and hung onto his mother. He did have a marked squint, but he was not wearing any glasses.

The next day Lois showed me a letter from the Glenrose which had just arrived, saying that the glasses that had been prescribed had not been obtained. Lois said, "I wish this had come before the visit, I would have followed up more on those glasses." She decided that as they might be moving to Calgary she would leave another visit until the New Year.

In February Lois said to me one day after clinic, "Do you remember Michael - the boy with the glasses? (4/2/80) It turned out that his parents had never got his new prescription, he was still wearing his old glasses." Lois commented, "No wonder he couldn't see." She had visited earlier in the week and had seen the mother alone. "I hope she is going to move, it seems it may be financial because she sort of hinted at that." Lois, had told her if she had financial problems she should arrange to see a social worker at the Glenrose. She added, "Michael was dropped from the Glenrose programme because he was not making progress without his glasses, the parents are viewed as uncooperative." Even with effective communication between the referring agency and the nurse problems are resolved slowly. It was unfortunate that the first visit was made the day before a letter arrived, then the parents indicated they might move and Lois felt it best to wait in case the situation had to be picked up by another nurse.

Commenting on Michael's family a few weeks later, Lois said:

> The last contact I had with the mother I felt I was getting through to her...and that she was really telling me the [true] story. Before it had been a bit glossed over I think, and it helped that I had contacted the Glenrose to find out what had happened as far as them dealing with the family. I did feel fairly hopeful...that I had got the message across that it was a very handicapping thing for him [Michael] to be without the glasses. (25/2/80)

She added that she felt badly not getting back to the family sooner, "but I've just been swamped. It's not my bag now really to keep following up these contacts...but I know this family and think I should have one more go." At this point Lois had handed over her job as infant and preschool nurse to her successor, but she felt that it had taken so long to get the family moving that a new nurse at this point might be detrimental to progress.

> I find with families like that, timing is always a little tricky to work out. You don't want to be on their back so much they get fed up with it and won't go ahead with what you're trying to get them to do, - on the other hand you don't want to leave it so long that nothing gets done.

Here, Lois indicated another area in which judgement is required, the timing of visits, in order to get clients to follow through with a proposed action. In this instance Lois' optimism was misplaced. For while Michael's mother had made an appointment with the optometrist she did not keep it as Michael was supposedly sick. Lois handed the family over to the new infant pre-school nurse.

Decisions Regarding Continued Follow-Up

I asked Lois what her criteria were for deciding when to terminate visits to a family:

> Well, Michael is unusual [in that he is older]...I picked up from a report that there was some problem with the mother carrying out the suggested care and going for appointments. [That was why the visits

> were initiated]. With a new baby...if I feel the mother is coping at the initial visit, if she has plans to see the doctor and if she will come to clinic, then I will not make a repeat visit. If she seemed to need more support...for instance if she was anxious, particularly if I felt she wasn't going back to the doctor and the baby was premature, I would go back again. With all mothers I visit I would check at three months to see if they had been to clinic and if not contact them again. (25/2/80)

Lois indicated that the assessment she carried out in a first visit was essential in her decision about the need for follow-up care. At the three month period if the child was having immunizations in the doctor's office, she would, "probably check again in a year or eighteen months and perhaps at three years." If the children were being followed through the neonatal follow-up program," I would not be concerned about trying to follow them ourselves as they are being looked after elsewhere." Lois decided to follow Mrs. Schwerkov because of her high anxiety but, "if I'd been really busy at the time, I would have terminated after the visit you made with me, she was anxious but really was doing fine."

A Communication Breakdown

Ruth had seen Laurel and her mother, Mrs. Arcand in clinic when they came for Laurel's first immunization. There was no birth notice on the chart and Ruth concentrated on the mother's questions about feeding and did not get much information on the social background. There was obviously some friction in the home as Mrs. Arcand mentioned several times that her brother-in-law was always drunk and that her husband went out with him. Because of Mrs. Arcand's complaints of fatigue she recommended she contact her doctor. (4/12/80)

The next day Lois enquired how Mrs. Arcand had been and Ruth told her there was no birth record, and thus no assessment of her home situation.

> There should have been - I made the home visit and I'm sure it's on the file [went to look]. That's so annoying it was filed right, perhaps the new clerk did the check - I must find out tomorrow what happened. (5/2/80)

The client was a young mother whose baby had been pre-term, so Lois had made the initial visit.

> She was separated from her husband - he had a drinking problem. I think she was on social welfare. She seemed to like the baby and was giving adequate basic care.

However, she had changed the formula since the baby was discharged and Lois had felt the child looked somewhat under nourished.

> I felt she was not too willing to listen to professional advice. She used her girlfriends and she had her own definite ideas. I had a feeling my persuasion about feeding would have little effect.

Ruth had picked up the same sort of feelings at the clinic visit. She found that the baby was underweight compared to her height on the growth chart. Laurel was on rice Pablum and had a rash, which appeared to have started at the time the Pablum was introduced. Ruth had charted:

> Suggested that she discontinue Pablum as rash appeared on face at time of starting Pablum. Not convinced mother will follow advice. Suggested she change to soya Pablum if she feels solids are necessary.

The mother complained she was feeling tired and she certainly looked as if she was. She was caretaking an apartment block and babysitting three other chldren. When Lois read the notes she called the mother and spoke with her again. Mrs. Arcand was still separated from her husband and on social assistance. She had seen the doctor regarding her symptoms of fatigue and dizziness and he had given her iron tablets and she was feeling better. (13/2/80)

If Lois had not noticed that Mrs. Arcand had been in and checked her record it is probable no further follow-up would have been carried out. Due to time constraints in the clinic, it was shown that Ruth did not obtain a thorough social history, unless the client presented with an overt problem. Here, the fact that there was a new clerk in the clinic, resulted in the misplacement of a birth notice that contained important information on the client. In this case it would not have been critical if Mrs. Arcand had not been contacted as she did see the doctor but with some clients where the baby seems not to be thriving, or where the mother has a problem, lack of continued care could be critical.

Summary

In Lois' contact with clients in their homes she demonstrated that listening and support are important actions in working with clients. Her clientele are mainly families who have had, or are having, problems with a child, so her function is to prevent secondary crises from occurring. Because she deals with some clients who have multiple social problems intervention may only be successful in relation to one specific problem, such as the adjustment of the mother to the baby. A long history of social problems may impede nursing action, as may a lack of parent motivation, particularly with low income families. Lois emphasized the importance of observing the physical care a mother gives the baby as a means of assessing maternal function. She also used the family support system and the mother's anxiety level as criteria for assessing the need for continued home visits. Communication between agencies or within the agency acted as impediments to client care. Available time also influenced the decision as to whether or not a family could benefit from continued visits. For example, when the work load was heavy termination of visits may occur earlier than would be the case when the workload was light.

The Clinic

Because of the nature of Lois' work it is necesary to look at her work in the clinic in the mornings as well as her visits with clients in the afternoon. She described her mornings as being occupied with paperwork and telephone calls, unless she had a meeting to attend. About once a week she would use a morning to go out on home visits if she had several calls to make.

The Morning in Clinic

On the morning I will describe, which was typical of a morning in the office, Lois came in, talked with the district nurses over coffee, then went to her office. One of the interview rooms doubled as her office and she did not have a desk in the big room with the other district nurses. In a way this singled her out, she was also the resource person on any policies and procedures relating to maternal, infant or pre-school care, so saw herself as, "probably more involved with recent theory and more aware of the policies than the average nurse." (19/10/79)

On this particular morning Lois was sorting and classifying the birth notifications which had been distributed by Central Clinic. First she had to check each notice and classify any "at risk" factors, there are ten categories set out by the agency, that must be coded. Then the births were entered in a record book, after the nurse had visited and the birth notices had been returned to Lois. She then checked the visit off in her book. In this way she checked to see that all visits were carried out by the district nurses, or if they were not completed she identified the reason. She also entered all at risk families in a special register. Lois had about twenty birth notices, but when she came to sort them out by districts, she found she had four that belonged to the clinic that bordered on Greenfield.

> Now these will have to go back to Central. They have a new clerk sending out the notices and she is not familiar with the boundaries. Sometimes when one clinic has one side of a street and the next door one the other it does make it difficult. (26/11/79)

Checking the Records

After the birth notices were completed Lois checked the client records from the previous two days of clinic. This involved reading over each nurse's notes, underlining, in pencil, critical points which needed rechecking at the next visit and putting a coloured marker on the corner of any records where the child had particular problems. These flagged records were the ones Lois checked monthly to see that the mother was continuing to bring the child to clinic. This task took the rest of the morning until lunchtime. Lois told me that she sometimes has to refer clients to the district nurse or contact a doctor as a result of information charted in the records. "As the district nurses are not in [clinic] on a daily basis it helps them if I make referrals and do follow-ups." While this sytem generally works, if Lois herself is away for any reason delays can occur, as was seen in the case of Mrs. Lubbertz and Mrs.

Heston, who were referred to the district nurses in their respective areas by Ruth (Chapter 6).

Typical of the sort of follow up that she does, is the following example of baby Brenda Shocter.

At the age of two months and three weeks Lois had herself seen Brenda Shocter in clinic (26/11/79). She had charted:

Skin	Babe has had persistent rash on face and hands and now in diaper area, rough, dry eczema like. Was on hennacome ung. and has improved - not using anything now.
Hips	Gluteal folds assymetrical, R leg held in more abducted position than L . Suggested mother ask M.D. to check this.
Feeding	Breast fed babe - taking some apple juice as well appears to be thriving.
	Persistent crying, but quietened some when rocked and comforted - close to feeding time - also seemed sensitive to handling by stranger.
	Babe had cold recently - slight fever - better now.
Next Visit:	Please ask re family and personal Rx - could not complete due to crying. DDST please.

In checking the visit the notation regarding the hips was underlined to bring it to the attention of the nurse who next saw the child in clinic. The information on the required actions for the next visit were also added in pencil when the notes on the record were checked.

In January Brenda was seen by Ruth, who charted on the record at the end of the visit.

> Family planning - I.U.D. through birth control clinic. DDST 4 1/2 months. Breast feeding only. Gaining ++. No concerns. Mum very relaxed today. Babe good during interview until close to end, started fussing and crying. Pronounced increase in crying when needle given and crying continued for length of time after. Was very irritable with last needle. Discussed giving Tempera, etc. (21/1/80)

When Lois checked the notes she noted that the history and DDST had been completed. As there was no notation on the chart to show whether or not the hips had been checked by the doctor since the last visit Lois added a note to the record.

Next Vist: Please check hips.

> With this mother I am not too worried, she is the type to follow-up with her doctor...but they [the nurses] do not always check properly, so I would like it double checked to be sure.

Lois appeared to chart in more detail on the records than most of the other nurses. She described the child's behaviour, such as the crying and response to comforting, in detail, as well as physical conditions such as the rash. Her notes provided for continuity of care if the client was seen by another nurse the next time she came to clinic. For example, Ruth had obviously picked up the comments on Brenda's crying and had evaluated her behaviour when she saw her at the subsequent visit.

Telephone Calls

During the hour and a half period that Lois was busy with the records she received three telephone calls. The first was from the mother of a nine month old baby who was concerned because she thought he was sleeping too much. Lois enquired whether he was alert between naps, whether he played when he was awake and whether he was eating well. When she received a positive response to all three questions, she was reassured that the sleep was not related to illness, so explained to the mother that children did vary greatly in the amount of sleep needed and that her son seemed to fall within normal variations. "If you're still concerned bring him into the clinic and we'll check him over for you, but from what you have said I feel you don't need to worry."

The second call was from a mother who wanted to take her eight month old child to visit her grandparents. This meant a full day's drive. She was concerned about feeding en route, upsetting his routine and whether there were any special precautions she needed to take. Lois asked her whether the baby would still fit in a carry cot and asked if she had a car seat. "If the car seat is a little big, you can pad it with rolled diapers, but if the baby is awake he will often prefer to sit up." She suggested using a freezer block in the bottom of a carrying bag to keep the formula fresh on the journey and reassured the mother that babies of the age of her daughter usually travelled well. Both these inquiries were related to normal, healthy children, the mother needing guidance, but not medical input.

The third call was from a mother who was due to bring her sixteen month old son to clinic that afternoon for his diphtheria, pertussis and tetanus booster. His sister had developed a rash, the cause of which was as yet unknown. Lois told the mother:

> From your description it could be measles, there is an outbreak in the city at present. As the booster shot is not really due until eighteen months it is not urgent he get it, and in case he develops an infection it is probably better postponed.

Lois had to call on her knowledge of child growth and development in counselling the first two mothers and her knowledge of communicable disease in the third instance. When speaking of the type of calls she gets in clinic, Lois commented, "Really, they are the sort of calls that need a common sense reply, but often mothers don't know where to get them answered". Certainly the calls I observed confirmed her perspective.

Postnatal Parenting Class

Lois had been holding a class, once a month for post partum mothers. This was an innovation that she had been trying in Greenfield Clinic which was not part of the general programme set out by the agency. When the nurses went on home visits, they handed out a slip with information on the class and asked the mother if she would like to come. In the situations I observed, the nurses approach was very low key and they did not attempt to point out any benefits from attending the classes. Lois told me her focus was on feeding, safety, discipline and toilet training, but, "it would depend on the interest of the mothers who came." She reported that four to five mothers had come, but that at the last session she only had two, so it was decided to abandon the project, "at least for the moment." (29/10/79)

There was a postnatal night held for parents who had been to prenatal classes. This had a fairly flexible format and depended on parent interest. In November Lois was talking in the coffee room about a class she had participated in the previous evening:

> We had a weigh-in at the end of last night's class - one mother wanted her baby weighed and then they all joined in. There were eighteen who came - but I think the mothers tend not to come if they are having problems - and that's a pity because we don't pick up the high risk families. It turns into more of a show and brag night for those that do come. (25/11/79)

Despite the fact that Lois believed that classes could be used to teach parenting skills, she had not seen much success from those in which she had been involved. She believed the mothers who may need help do not make it to class, thus defeating Lois' purpose.

Mothers Orientation to City Health Services

Another morning activity twice a month was the visit to one of the local hospitals where Lois was responsible for interpreting the purpose of the City Health Clinics. She had told me that attendance was poor and at the class that I observed there were eight mothers and eight student nurses present. Lois outlined the work of the clinic and one multipara, who had been to clinic with her first child spoke positively of the services offered. During the session Lois answered the mothers' questions which were related to feeding, crying and normal stools. She was unhappy at the low number of mothers attending as the hospital averaged 14 - 15 deliveries a day. With six post partum wards she saw individual visiting as unfeasible.

> The problem is that the mothers who come are the ones who are already interested. The nurses on the wards don't see it as important. We've tried talking to them, we call to remind them the morning of class, but still they don't encourage the mothers to come.

Lois also had leaflets available on the clinic, on feeding, discipline, normal development, and child safety that the mothers could take if they wished. All of them looked at the information and selected the leaflets of interest. The mothers who came responded positively to the talk. The hospital allocates a room in the basement, next to the laundry collecting unit, so the community health nurses do not see the hospital nurses unless they go up to the wards. It is also an effort for the mothers to attend as they have to find their way down to the basement where they have to sit on hard chairs to listen to the talk. This setting is not conducive to a relaxed talk when you have a sore bottom as mothers do!

Lois had met with the nurse from the adjoining clinic, who runs the class alternate weeks, and they plan to talk to the maternity supervisor at the hospitals, to see if alternative arrangements can be made. However, Lois is not very hopeful as she has not received much co-operation when she has met with her in the past. So, despite her belief in the importance of group education, her efforts do not seem to be successful in relation to either of her post partum classes.

The Afternoon In Clinic

Lois' afternoon in clinic was similar to that of the district nurses. As clients were seen in order of appearance at clinic they were not scheduled to visit a particular nurse, therefore Lois could be expected to see the same mix of clients as any other nurse. Lois felt that because the clinic was not particularly busy, there was no pressure to conclude visits strictly within the time allocated.

> A lot of visits are just the one time visits, you haven't seen the client before and you often don't know what you're heading into. I do have the advantage that I often remember clients from their records. (19/10/79)

I asked Lois how, with the lack of continuity of care, she knew she was meeting client needs.

> Well, for me it's easier. Next time they come back I can look at the record. For instance with a baby that's not gaining weight and you make some suggestions about changing diet or getting to the doctor... if she comes back the next time and you see a gain in weight you know something positive happened. In a visit I think the response you get, it's more on the psycho-social level of giving support, just from what the mother says and the fact she seems more relaxed and confident. (28/11/79)

Lois and I also discussed the effect of agency policy on the advice she gave to mothers in clinic.

> Pretty well I try to fit my advice within the policy...being in the position I am, where I am attending meetings where some of these policies are directly handed down to us, I feel maybe a little more, required, perhaps, than the other nurses to adhering to the policy because of the fact that I am the one passing it on to the others [on matters] that relate to infant and pre-school. (28/11/79)

This was noticeable when Lois came to give advice to mothers on the use of an analgesic, when requested, following immunization. Lois generally said "Consult your doctor", where other nurses would either enquire what had been used previously or suggest several medications that could be used, leaving the mother to make a choice. In her counselling Lois was also inclined to use the word, "We", implying that the agency suggested that the mothers do certain things. "We like to get a history, so we have have some baseline data." "We generally do not advise 2% until the baby is a year old". This again tends to suggest a strong identification on Lois' part with the agency and its policies.

A Conflict Situation

I asked Lois who sets the agency policies that the nurses in the clinics are expected to follow.

> It depends, mostly the nurses have input. I think the one relating to analgesics though was imposed by Dr. Short [the medical officer responsible for infant and pre-school care]. I think it was in response to outside physicians who wanted their patients to have certain [medications] and we'd recommend other things and they thought we were treading on their territory. (28/11/79)

Usually, the policy is derived through consultation with the nurses, which Lois says means that the policies "are easier to go along with.... and certainly we get a chance to discuss it before it's implemented." In contrast to the nurses at Redfield Clinic (Chapter 5), she believed the scoliosis screening, for example, had been discussed before its implementation. However, despite the fact that she followed the policy on advising mothers on medication for fever, she had reservations.

> I find there is controversy over that policy. To some people no advice is poor nursing and just to call your doctor is no advice. I don't always feel comfortable with it and I'm sure it will come up again [for discussion] as far as policies are concerned. (28/11/79)

When she has had clients who want their blood pressure checked, "I phone the physician and ask if they have any objection to my telling the person the result." Lois does not agree with the policy, "and fortunately when I phoned they agreed there was no reason for them not to know what their blood pressures were". She added, "I get quite annoyed about that policy." Again she saw it as a case of, "administration kowtowing to the physicians", instead of selling the role of public health nursing in, "prevention of disease". "I think these situations stand out because they have been imposed, in contrast to most decisions where we do have input."

In December Lois saw a client in clinic, who asked if she would check his blood pressure. Mr. Frunchak had come to clinic for an influenza injection. The clinic had advertised that they were free to senior citizens. He asked to have his blood pressure checked, "because it has been up." When she had checked it Lois said, "I must contact your doctor to get permission to discuss this with you." She asked the name of the doctor and got through to the office. While the doctor was with a patient when she called he did return her call as soon as he was free. After receiving permission to talk to the client, Lois told him his pressure was still elevated. She then proceeded to check whether Mr. Frunchak was taking his pills regularly, his habits relating to diet, exercise and rest and whether he was having any emotional stresses. Mr.

Frunchak was living with his daughter and there was some tension in the household, he was on the waiting list for a senior citizens' home, and seemed happy about the proposed move as he had a friend there. Lois listened to his concerns and checked to see he knew whom to contact about his application if he felt things at home were becoming too stressful. She also offered continued support, "You can call the clinic if you feel you need someone to talk with, the nurse in your area can come out."

After the visit Lois said she did not know what she would do if the doctor said she could not speak to the client.

> If he disagreed I would feel in a bind, but I wouldn't feel it unreasonable to say how I personally felt. I really feel that in implementing this policy the physicians were dictating...stepping back into the old role where the patient shouldn't be informed of things because he'll get all mixed up about them....It's ignoring the fact that with teaching they can understand the implications. (4/12/80)

In the visit with Mr. Frunchak she did go through the process of checking out his ability to follow his medication orders and identifying lifestyle factors that might contribute to elevating his blood pressure. She offered him support if he needed it and did provide information to help him understand the relationship between stress and an elevated blood pressure. Lois has dealt with the administrative policy in her own way in her daily activities but there seems to be no move to take it back to the upper administrative level, in an effort to have it changed. However, this policy does not fall within the scope of the infant and pre-school committee of which Lois is a member and concerns would have to go via the clinic supervisor to the director of nursing.

Culture and Conflict

Lois indicated that she felt that when she was working with clients she was generally accepting of their point of view. In both the home and clinic setting she had to work with families whose cultural orientation was different from her own. One such group were the Italian and Portugese families, who she viewed as having similar cultural values.

> We have a lot of Italian and Portugese mothers who come in. They tend to start solids very quickly and they like big babies - plump arms, plump thighs - it's very difficult to counsel them as so often they have limited English, often the mother works and the babysitter, often grandmother or an aunt brings them in. They are good about getting the children immunized but sound nutrition is another matter. (22/10/79)

Lois identifies the cultural values of these families but believes the nutrition to be unsatisfactory. In Kate's schools there were several children from these ethnic groups and they were, almost without exception, overweight. This suggested that they were likely to incur future health problems and so failure to change early feeding habits conflicted with the nurses' notions of preventive health care. An example of this type of situation was evident when Melissa, 5 months of age, came to clinic. She was at the 95 percentile for weight and the 75 percentile for height, so was clinically overweight. She was brought to clinic for immunization by an older lady, who Lois thought was the grandmother. ~~The~~ The family were Portugese and the grandmother spoke little English.

Grandmother: Me have baby every day.

Lois: Did she have a fever with the needle?

Grandmother: She okay.

Lois: What is she eating?

Grandmother: Me, no understand.

Lois: Does she drink milk?

Grandmother: (pointing to storage can) One that size.

Lois: The same as the last time you came?

Grandmother: Me, no understand.

Lois: She's a big baby (shows with hands).

Grandmother: (Laughs).

Lois: Any teeth (points to own)

Grandmother: No.

Lois: Still lots of time.

Lois began to prepare the injection for the baby and the grandmother started to pull the child's sleeve up.

Grandmother: This one? (Plays with baby).

Lois: Yes, thank you. Does your daughter read English?

Grandmother: Yes.

Lois: Melissa may have little fever (touches head), or be hot tonight. This (instruction sheet) will tell your daughter what to do.

Grandmother: Yes.

Lois: She should come back in two months - I have the date on the card.

Grandmother: Thank you. Bye-bye.

Here the client was most co-operative but the language created a real barrier to communication. Lois commented:

> I would have liked to find out more about the diet - but there seemed no way to start. This child at 3 months was on cereal, fruit and vegetables. She's at the 75 percentile for height but the 95 for weight - so she's a big child anyway. This early feeding does tend to make them gain too much.

The child did have chubby legs and thighs, but seemed bright and active, attempting to escape from grandmother's lap. The grandmother played with her and the child smiled readily. Lois felt, "her overall development seems alright I'll just make a note for the nurse to watch that weight."

On a home visit Lois made to an Italian mother with a handicapped child she encountered similar problems. Antonia was six months old, a happy youngster, who grinned at you with the slightest provocation. Her elder sister, Katrina, had had anoxia at birth and was being followed at the Glenrose. The mother had good support from her parents and seemed to be coping well in a situation in which she virutally had two babies, as Katrina, at three, still had to be diapered, washed, dressed, fed and she could not walk. It was when we got onto the subject of Antonia's diet that Lois became concerned.

Mother: She eats everything, meat, vegetables, cookies she really like. I make all my own food.

Lois: What kind of cookies? Sweet or hard rusks to chew on?

Mother: Chocolate she like...and sweet ones, plain one's she don't care for.

Lois: It is not good for her to have too many sweet things. They are all calories and do not help her grow. She is a big girl and she needs milk and protein.

Motehr: She drink milk...she like chocolate milk too.

Lois: Plain milk is better for her at this age.

The mother indicated that she generally had plain milk and remarked she was due to come to clinic for the second immunization the next week, which indicated she was on schedule. Once again Lois encountered a caring mother, but with a cultural background that promoted large babies as healthy and who was unlikely to accept advice. Lois commented:

> Both the Portugese and Italian mothers like to get them on solids early...their diet is well balanced, milk, meat and vegetables. She

> could do without the cookies - but the men seem to like their women plump, it's hard to alter a cultural pattern. (27/11/79)

Lois believes clients have the right to manage their own lives and make their own decisions. Here she does provide information related to the immediate situation but does not go beyond this to identify the long-term implications of overweight. However, she is only minimally concerned with Antonia's weight at this stage, and judging that she has a well-balanced diet, she is content, in light of the cultural factors involved, to continue to monitor the situation.

A Possible Case of Maternal Maladjustment

When Lois described what she looked for in evaluating maternal behaviour she said:

> I think probably her handling of the baby is critical, whether she is holding it close to her or whether she is holding the baby at all. Whether she seems to respond if the baby is crying, whether she picks it up and tries to comfort it. Often she is relating things about the baby, whether she enjoys the baby or not, whether this is a good experience for her, how relaxed she seems to be with the whole situation....this really gives me clues. There are mothers, like Mrs. Schwerkov, who seem kind of anxious and concerned, and I would still say things were fine...it would probably be how much reason they had for being concerned that I would look at here. (25/2/80)

A mother who gave her cause for concern was Mrs. Richards, who came with her three month old son, Brian, to clinic. When the mother came into the office Brian was crying loudly.

Lois: (To baby) That's a sorry business.

Mrs. Richards: His bottle's too cold, he won't take it.

Lois: Do you want to warm it up? I can just run it under the tap.

Mrs. Richards: No, he can wait.

Lois: Was there anything you wanted to ask about - any problems.

Mrs. Richards: No, not really.

At this point Brian started to cough, so Lois enquired whether he had had the cough long, "No, only since last night." Lois asked about fever, and the mother said he had only had the cough but her older boy had bronchitis.

Lois: I notice he's kind of red around the eyes here.

Mrs. Richards: He gets that way when he cries.

Lois: When he cries...these spots here?

Mrs. Richards: He's been treated for yeast infection, but the doctor says he can have his immunization - that's the end of it.

Brian was a pale, thin looking baby, and as Lois looked at him she observed several deviations that she needed to check out with the mother. When she went on to discuss the rash, Mrs. Richards reported that he was allergic to Pampers (disposable diapers). He was wearing them on his clinic visit.

Lois: Does he usually wear something other than Pampers?

Mrs. Richards: Yeah, at night. It's a compromise really.

Lois: If you want to use disposable diapers there are other types that might be better for him, (examines Brian's penis, which appears raw). Was this some of the yeast infection?

Mrs. Richards: Mmhh. (Brian cries loudly, sobbing).

Lois: Does he seem to have problems when he passes his urine?

Mrs. Richards: Nope.

Mrs. Richards did not volunteer any information, she answered the questions with a brief response. Lois did not pursue the matter of the rash any further but turned her attention to Brian's crying.

Lois: Has he been more fussy - since he's been having a cough?

Mrs. Richards: No. He's really been good until right this minute (puts Brian's fist in his mouth, crying subsides).

Lois found dried stool in the buttock crease, and got a wet swab to wash the area, "There are some spots here that are hard to reach, you don't always see them when you change him". The mother replies, "Right". Brian began to cry once again and Lois remarked, "You lost your fingers didn't you? Are you upset without them?" Lois returned his finger to his mouth and he sucked vigorously. Lois checked out Mrs. Richard's pregnancy and delivery which she reported to be uneventful. When she asked if Brian had been to the doctor, Mrs. Richard's laughed and said, "many times". It appeared that he had had three bouts of monilia and had been seen by two doctors, who both agreed on the diagnosis. Brian was screaming again and Lois once again asked Mrs. Richards if she wouldn't like to give him the bottle, she responded, "No". Lois continued with the family history and Brian cried constantly. Mrs. Richards held him in the crook of her arm, but did not take any action to comfort him. Finally he found his fingers again.

Lois: (Shaking rattle at Brian). It's the fingers that do the trick!

Mrs. Richards: It has to be that left hand finger.

Lois: Well, it's often useful if you can find something that will do the trick.

Mrs. Richards: The first one never did - he had a soother for about four weeks - then he never sucked his fingers. This one does. (Brain yells again).

Lois: Do you have far to go home with him - because you could certainly warm the bottle here if you wanted....?

Mrs. Richards: Nope - it's not long since he's been fed.

For the first time Mrs. Richards indicated that she does observe Brian's behaviour, when she said, "It has to be that left hand finger." Lois, still tried to direct her toward Brian's needs, but she did not respond. Lois was testing Brian's eyes, but he was not co-operative. Mrs. Richards tells her he does watch his mobile.

Lois: I think right now he's thinking mostly of.../

Mrs. Richards: (Interrupts) He's very stubborn.

Lois: Is he? How do you see that?

Mrs. Richards: Oh, temperamental - if he doesn't get his own way that's it - like his father. He screams and cries.

Lois: And how do you usually react to him when this happens?

Mrs. Richards: It depends on what I'm doing at the time. (Brian was drawing in a breath and was quiet. Lois rang the bell to test his hearing and he started crying again).

Mrs. Richards: He's a very nervous baby. Any loud noise and he just starts to cry.

Lois: When he is crying and you do pick him up does he quieten down easily?

Mrs. Richards: Yes. (To baby) Shh - Shh. It's okay (voice softer)

Lois discovered Mrs. Richards had three children in the house, the eldest, a nine year old, "wasn't born by me". Her husband did not help her at all, "but", she said resignedly, "we'll survive". She did have a, "good babysitter and so I can get out". Brian started coughing again and sounded quite chesty.

Lois: I'm just wondering with that cough - it's on his chest when he coughs.

Mrs. Richards: He doesn't cough much.

Lois: I think with that cough, as it's just starting, I'd just as soon wait [to immunize], until he's seen the doctor...and see if he feels it needs treatment before we...he may need medication...(Brian is still screaming). Try putting him over your shoulder... that sometimes helps.

Mrs. Richards: (Pats Brian's back). Okay, shush...shush.....

Lois: (To baby) You're so noisy (quiet voice). You're so noisy. (Brian's cries subsides, sobbing now).

Lois told Mrs. Richards that Brian appeared to be average in development, "but when he's not very happy it's not too good to try to assess him". She suggested Brian could come back in two weeks if his cough cleared up.

Lois: What are you feeding him?

Mrs. Richards: 2%.

Lois: Was it the doctor suggested that?

Mrs. Richards: Nope. I suggested it and the doctor gave me heck (laughs). Anything you mixed with water came right back up. You give a bottle of water and it comes back up - so it has to be milk.

Lois always checks to see what the doctor has ordered before she advises mothers on nutrition. "While there are some good reasons why the baby should have homogenized, as long a the baby is gaining I'm not going to confuse her if she is following her doctor's advice". However, Mrs. Richards was going her own way and Brian was clinically underweight.

Lois: Have you tried homogenized?

Mrs. Richards: Yes, but he was really cranky, so I put him back on 2%. He takes pablum - and at one meal he'll have his meat and fresh vegetable. (Brian is really crying hard again and Mrs. Richards is ignoring him).

Lois: I don't think he can hang on any longer. We have an empty room, why don't you sit and feed him?

Mrs. Richards: I just gave him a bottle a little while ago - he can't be that hungry.

(Brian is almost hysterical in his crying by now).

Mrs. Richard: Now we're into the real fun part. (Holds Brian away from her).

Lois: We can warm the bottle.

Mrs. Richards: Okay. (Sounds exasperated). He's angry isn't he?

The mother and nurse left with the baby. When Lois returned she said, "He was just too upset to eat, so mother took him home". In discussing the visit Lois identified several conflicting behaviours she had observed.

> Oh dear! I don't know. I don't feel happy about that relationship with her. She was a mixture really - she was saying "he's angry isn't he", not really sensitive to what the baby was feeling. At other times she was consoling him, holding him close, giving him his finger to console him...I think she really has ambivalent feelings - that's what comes across. I wish she would have let the poor little fellow have his bottle...I gave her several opportunities, yet she didn't seem to feel that was it. If it was, it was as if, no - he's not going to get his own way...and then she referred to how stubborn he was...like the father. I wonder if there's something more to that, particularly if he doesn't help much. (25/10/79)

Lois built a composite picture of the interview as she looked back on her visit with Mrs. Richards. She was concerned about Mrs. Richards behaviour but not sure how to proceed.

> I don't quite know what to do - I'll see what they found on the home visit, certainly there seems a potential for involvement here. Particularly given the 2% milk - sort of the crowning touch for everything. Yet she's aware of the problems...but the Pampers, she's still using them. She doesn't seem willing to make compromises for the baby's welfare, it doesn't seem easy for her to do the right thing for the baby - it's a mixture again of the right and the wrong thing. She mentioned how different he was to her first child too - she mentioned her first baby did not cry and outside she said she finds it harder with this one. So she's a Mum I'd like to follow fairly closely and I think see what happens, whether she comes back in - whether we see her again, and if not follow-up with a home visit.

This case was typical of the problem-to-find nature. Lois asked herself, based on the evidence, was there a problem and if so what was that problem? She went on the reflect on Brian' behaviour during the visit.

> Certainly the baby wasn't acting - wasn't easy to console - but I feel if she had given a bottle early on before he got so worked up [he would have been consoled]....She was kind of curt initially in her talking with us...but I think the baby had been crying outside,

> so she was probably rather tense to begin with....I don't think she was too happy about his not being immunized,..but that cough really sounded like there was something going on there...and I'd rather not give it at this point, particularly if it had just started. It certainly wasn't just something in the nose...but he's one of those babies that looks rather thin and not thriving...maybe.

Lois put a red flag on Brian's chart, "so it gets reviewed next month". Within the month, Mrs. Richards telephoned and spoke to Lois, reporting that Brian had indeed had bronchitis and had been admitted to hospital. (28/11/79) Lois' caution with the immunization was therefore justified. The information Lois charted on Brian's record covered all the points she outlined in her discussion with me. She noted that at the next visit the DDST should be completed and the cough, rash, feeding and maternal-child interaction should be checked.

At six months of age (24/1/80) Mrs. Richards brought Brian to clinic for his third immunization, the first two having been given by the doctor. She was seen by Vera, who was also concerned about the mother's behaviour. She charted:

> Baby crying. The mother calm, held baby away from her, thrust him at the nurse when she held out arms. Cuddled, sobbed and quieted. Refused bottle. Sucked 1st finger and then accepted bottle. Mother admitted she became upset when he was angry - no use comforting him, "just spoiled", "bad tempered" - then stated usually a "good baby".
>
> Whooping cough before Christmas, bronchitis 3 weeks ago, wheezing infrequent cough now. Mother anxious to have immunization as he is "sick so much".
>
> DDST not attempted. Not weighed/mother declined. (24/1/80).

Vera discussed the situation with Lois in the coffee room and said she would like to make a home visit herself, but it was not within her district. Lois discovered Mrs. Richards lived in Central Clinic's area and visiting out of the clinic's own area, "was not encouraged". A nurse from Central Clinic could be asked to go out, "but we've tried that and the communication doesn't seem to work". Finally they decided to assign a nursing student to Mrs. Richards and called Central Clinic to get permission. This did not work out, because Mrs. Richards went out of town at the beginning of the field work period. At the conclusion of the study period Lois had decided she would, "visit Mrs. Richard to explain why the student will not come". She lived on the boundary of Lois' district, "so it will not be out of my way".

Mrs. Richards illustrates some of the difficulties the nurses encounter, after identifying a problem family, in providing continuity of care within the framework of agency policies. While Lois sees herself as independent and able to make decisions for the benefit of the client, her plan for follow-up was finally devised in an attempt to circumvent the problems that she identifed as inhibiting what she believed to be appropriate nursing action. The visit with Mrs. Richards also illustrated the criteria Lois used to assess the client, her collection of data on the client and her subsequent use of the data to evaluate the situation.

Initiating a Home Visit

In some respects Lois' initial hesitation to make a home visit to Mrs. Richards may be related to her own feelings regarding the difficulty of initiating such visits. She spoke of another client who she wanted to visit at home, but seemed almost reluctant to make the move although she had seen her several times in clinic.

> There's one little gal, who was into clinic yesterday - I made the initial home visit and then I've made contact again in clinic...on that first home visit she was saying all the right things, pretty much....The baby was premature...so she talked about how that was for her when the baby was still in hosital and she was home...and she

> talked about how she was in every day because she couldn't bear to be away from the baby, but at the same time she seemed to express feelings that the baby had, you know, to perform and really did not want the baby to be spoiled. The baby had...a congenital dislocation of the hip, so initially was put into a splint but cried so much, I think this was after she was home, that they had to remove it and just try double diapering. And when she was into clinic yesterday, she was talking about this, it was with one of the other nurses that she saw. The nurse made some comment like, "Well, the splint must have been uncomfortable, and it was understandable that the baby would cry with it. She said, "Oh no, it wouldn't have been uncomfortable, it's just the baby cried." You know, giving the impression that the baby cried more to annoy her and I was getting a bit of that flavour on the initial visit but she was certainly - talking about how much she liked the baby. Both she and her husband seemed to be deriving some pleasure, but there was a bit of not wanting a spoiled baby and they weren't going to pick her up each time she cried - but this seems to have been coming across more strongly with subsequent visits - she also came in here one day, late on a Friday, and the baby was having diarrhoea - it was just pouring out, more or less continuously. She was upset and I think at that time I was able to be helpful to her. At this point, I'm not quite sure how to proceed with her, I feel that she really is having problems...she wants to do what's right for her, but she does seem to express some strong negative feelings. When I saw her out in the hall yesterday, the baby was fine as far as the diarrhoea, but she was wanting [to be picked up] up all the time and she [the mother] just couldn't do that. I really am feeling a little frustrated because I'd like to give her a chance to talk more about this and see if there are ways that I can help her. But I think that is going to be quite difficult. I'd like to make a home visit to her again, where I'd have a little more time and a little more freedom to go into that, but I'm not sure at all that she's very accepting of my coming in and trying to help, I think with having had several contacts and phone conacts with her as well, I think I have developed enough rapport with her that I'd be willing to attempt it now - whereas earlier I think she might have seen it as being quite interfering....I don't know that she has very much support from family or anything - I don't know if she has anybody she can turn to and talk about things, so I'd at least like to attempt it and see what happens.

Lois earlier had said about herself, "I do find it difficult to move into someone else's territory when you don't know if they're interested in having you there or not." In this situation she identified a potential problem and is debating her course of action as she weighs the pros and cons of making a home visit.

Co-operation with other Professionals

In clinic, Lois would sometimes encounter problems for which she did not have an answer. She was always willing to say to the client, "I'm not sure" and obtain a second opinion. In November Melissa Provost, who was 2 1/2 months old, was brought to clinic for her first immunization. When Lois had the baby undressed she asked Mrs. Provost if there was anything she was worried about. Mrs. Provost responded, "Yes, here" and pointed to the baby's umbilicus.

Lois:	(looking at baby). Has there been any discharge?
Mrs. Provost:	No, nothing, just redness.
Lois:	She hasn't got all that much of a protrusion...(looks at umbilicus again).
Mrs. Provost:	No, the other thing I found her elastic pants seemed to catch right here...I don't know if that had done it or what....
Lois:	Mmhh...keep an eye on it...it might/(to researcher). What do you think?
Researcher:	There could be some granulation tissue at the bottom there...see...(points to umbilicus)
Lois:	Do you think vaseline...
Researcher:	If it is granulating she may have to get the doctor to look at it...it will need cautery perhaps....
Lois:	Are you due to go to the doctor again soon?
Mrs. Provost:	At three months.
Lois:	Well, watch it and unless there's a change and you're worried show it to him then.

Since the introduction of cord clamps there has been a decrease in granulation of the cord stumps, therefore it is likely Lois had not encountered this before, she said afterwards, "I'm glad you were there, I had no idea what it was." Mrs. Provost also had a question with regard to "cradle cap", a common concern with young infants.

Mrs. Provost: There's a little cradle cap that's starting.

Lois: Yes, there's a little, how are you treating it, with baby oil?

Mrs. Provost: Just baby oil - yes.

Lois: We suggest sometimes trying cooking oil - it's a heavy oil.

Mrs. Provost: I tried that on my other daughter and she got worse.

Lois: Oh, is that right? Have you tried leaving it on and washing it off?

Mrs. Provost: I leave it on overnight and wash it off next morning.

Lois: And are you using a comb? Or does it seem to be clearing?

Mrs. Provost: Well, she had it on her forehead - and I got all that.

Lois: It looks good now - she's just got one little bit here. I'd suggest using a soft toothbrush to loosen the scale a bit.

Lois utilized the usual advice in the form of questions, so she could assess what the mother was already doing for the condition. Lois utilized "we" in conjunction with advice on using the cooking oil, I asked her about this, but she was not conscious of the fact that she used it to preface advice.

Cases of rash and cradle cap were sometimes more complex, as was the case with Stephen Hesse. Stephen was three weeks old, his mother lived on an acreage on the edge of the city but she had previously lived in the area served by Greenfield Clinic. She brought Stephen in because of a rash in the diaper area and on his head. Lois obtained a history and found he had had the rash for four or five days and that the mother was breastfeeding. When the baby cried, mother responded, "It's close to his feeding time. Oh, honey, honey, shh". This constrasts markedly with Mrs. Richards response to Brian. Lois asked Mrs. Hesse if she had seen the doctor and she replied, "No, my appointment isn't until 13 December. They suggested diaperine...but it seemed to make it worse." (29/11/79) Lois enquired how the mother laundered the diapers and found nothing in her practice likely to aggravate a rash. Lois was convinced the rash in the diaper area was a monilia infection. The rash on the face and head presented a different problem, it was red on the outside and clear in the centre. She told Mrs. Hesse, "I'm sure the rash on the face is not the same as that on the tummy". At this point the nursing supervisor came in and Lois appealed to her.

Lois:	Could you look at this rash for me?
Supervisor:	Um...it looks as if it was initially a cradle cap but it has got a secondary infection.
Lois:	But the raised edge?
Supervisor:	I have seen an infectious seborrhoea like that before...look at his eyebrows, they're full of it.

Lois said to Mrs. Hesse, "I think you should see the doctor as soon as possible, he [Stephen] does need treatment I think".

Mrs. Hesse said it was hard to get an appointment, so Lois said she would call and explain the situation. Because Mrs. Hesse had a twenty mile drive Lois tried to get the office nurse to take her that afternoon, but was unsuccessful, "They're already double booked". However, she did succeed in getting her in the next day. Lois obtained the basic information on the history of pregnancy and labour, family history, current infant feeding and the mother's support system. Because Mrs. Hesse was having some trouble breastfeeding she loaned her a copy of, The Womanly Art of Breastfeeding, as she had little knowledge of what to expect.

Lois found that the mother was relatively isolated on the acreage, her parents visited once week, but she was alone all day and did not know her neighbours. However, she said she was not lonely, "He [the baby] keeps you hopping". Lois was somewhat concerned about the mother following the visit.

> When I asked her about how it was for her at home...I got the impression...but I wasn't quite sure...that she was almost close to tears...her verbal responses would be that everything was fine...so I wasn't quite sure whether to say anything more direct about it...she didn't have any help...but she didn't seem to be looking for any. Generally she seemed to be alright and bonding with the baby - she seemed to be holding him close and I didn't pick up any concern at all - she did her best to settle him and was responsive to his needs - I think there's nothing to worry about. (29/11/79)

Lois is concerned about, and sensitive to, the feelings of isolation that young mothers experience. She listens both to the content and the feeling tone of the conversation. She said, "I think my years in psychiatric nursing taught me the importance of that". (19/10/79) While Mrs. Hesse presented with a physical problem with her child, Lois was able to deal with this effectively, her remaining concern was for the mother's social situation.

Respect for the Nurse as a Professional

Lois has said that she believed it to be important that the client saw the nurse as a credible professional. Mrs. Provost demonstrated respect for Lois' opinion in discussing feeding.

Mrs. Provost: I give her cereal in the morning...and sometimes if she'll take it cereal at night/

Lois: Mmm...

Mrs. Provost: ...sometimes she won't take it. She went off the cereal when she was sick...so I had to reintroduce it.

Lois: Mmm...had the doctor suggested giving the cereal?

Mrs. Provost: Oh yes! He wants me to start them on cereal at three weeks (laughs) and/

Lois: Through the clinics, we're not you know really encouraged, starting solids because/

Mrs. Provost: I figure they're not really ready/

Lois: They're not really ready.

Mrs. Provost: She doesn't seem too crazy about them, my other one never really was crazy about them either.

Lois: It sounds as if she is taking milk really well/

Mrs. Provost: Oh yes!

Lois: She's probably getting all she needs...it doesn't sound as if you need to push it.

Mrs. Provost: I won't then, if you think she's doing alright.

Normally, when a mother says the doctor has advised something Lois will not give conflicting advice. Here she picks up on Mrs. Provost's hesitation about the advice she has been given and reassures her that the baby will be alright without cereal. She does not explain to the mother any of the reasons why a later introduction of cereal is advocated, but in this case the mother is ready to accept support for her own preferences.

Mrs. Scott brought her four month old daughter, Karen, to clinic, because the baby had a cold and her doctor was away. She was concerned because, although the cold was clearing, the baby was, "still spitting up". The mother was breastfeeding. Lois had told me previously:

> The administrative policy now is to actively support all breastfeeding mothers and to encourage them as much as possible. (27/11/79)

It was not surprising therefore to find Lois encouraging Mrs. Scott saying, "you've really given her a good start". Lois enquired about the amount Karen was bringing up and the presence of mucus. Lois commented, "Do you think that, with the spitting up her tummy may be overfilled?" This mother showed herself to be knowledgeable responding with, "I thought they didn't overfeed if they were breastfeeding". Lois agreed this was somewhat unusual, but that it could happen. Mrs. Scott commented, "...maybe she takes in more when she's sucking now, she seems to feed faster." Lois reassured the mother that the problem probably was mucus from Karen's cold, "usually it's not too great a worry, as long as their not losing most of their feedings".

Mrs. Scott raised a new concern, what should she feed the baby when she weaned her at five months of age, "should I use Similac or just regular milk?"

Lois: We usually suggest up to six months you continue on something like Similac or Enfalac. Have you used either of these?

Mrs. Scott: No, I haven't - just the breast.

Lois: She'll take the bottle for you?

Mrs. Scott: Yes, she takes juice by bottle.

Lois: Usually they are better off on formula as those are designed to be as close to human milk as possible. (Karen chuckles) What's that eh? Can you see that? [Refers to mobile] Look! Watching aren't you? (To mother) Would you like me to do the developmental test with her today?

Mrs. Scott: Mmhh (assents).

Lois: You might check with your doctor as far as formula, although we usually suggest Enfalac or Similac until six months. Have you thought about how you will go about weaning her?

Mrs. Scott: I thought about continuing a night and morning feed... then Similac or whatever.

Lois: Rather than just switching. Often I think it's a good idea to do it first with one feeding, then keep at that for a couple of days, then eliminate another feeding, just gradually until she is weaned.

Mrs. Scott: Just gradually, Mmhh.

Lois: It's a good idea to do it [breast feed] at night...and then in the morning when your supply will probably be larger...then you can gradually eliminate those two.

Lois is careful in checking out Mrs. Scott's level of information, she says, "Have you thought", allowing the mother to take the lead. Her vicarious enjoyment of the baby is evident as she picks up, and responds to, Karen's chuckle. While she suggests the mother check with her doctor, it is probable that Mrs. Scott has already made up her mind that she will use Similac, however it was evident that she attended to Lois' advice. When Lois was evaluating the visit she said:

> The most important thing seemed to be reassuring the mother that the regurgitation wasn't serious - I think she sort of realized that - but she just wanted someone else's reassurance....She seemed fairly knowledgeable, probably a well educated gal, who seemed to be coping with her problems. I didn't have any concerns, she was enjoying the baby, she was observing the baby and talking to the baby, I thought there was a good relationship. The baby seemed alert the way she was watching the mobile, interested, relaxed and happy...I think the spitting up was related to the mucus...certainly it's not serious. (25/10/79)

Lois used both her observation of behaviour and the information from the history in drawing her conclusions, that all was well with this family.

Looking for Signs of Physical Abuse

Lois was always on the alert for signs of physical abuse, she felt that the area had more than its share of child abuse. While the four major informants in this study did not have any cases of child abuse to investigate while I was with them, all reported cases in the previous year. Over coffee several nurses spoke of cases they were following which ranged from a pre-schooler, who was noted in the day care to have bruising on his buttocks which appeared to have been caused by a belt buckle, to possible sexual abuse in the junior high school and child neglect in the elementary school.

> So many mothers in the area have a low self-concept, one needs to boost their morale somehow. Some seem to need a man - and a pregnancy - to tell them they're okay. They keep the baby and then they are so insecure, we have a high incidence of child battering in the area. (26/10/79)

The visit of the Roddicks was somewhat unusual, in that a young mother and father both came with their eight week old son, Colin, to clinic. While the father did not take much part in the conversation, he placed his chair where he could see what was happening, and watched the full Denver Developmental Test. The first questions were all directed toward the management of cradle cap, and Lois advised using a cooking oil, such as Mazola. She then placed the baby on the table prior to examining him. As she did so she noticed a raw red mark on his right wrist.

Lois:	I notice he has a red mark on his wrist.
Mrs. Roddick:	He has one of these little nighties/
Lois:	With the tight elastic in it/
Mrs. Roddick:	He must have wriggled it up you know.
Lois:	Yea, how long has he had that?
Mrs. Roddick:	He just did it the day before yesterday. His whole hand had swollen up - I took him to the hospital.
Lois:	Is that right - it must have been deep to last that long.
Mrs. Roddick:	There was blood under there before - but it's getting better.
Lois:	Are you still using the nightie?
Mrs. Roddick:	No (laughs).
Lois:	You can snip the elastic in the sleeves, so it's not really tight.

Lois examined the baby, talking to him as she did so, "Right, you're a good baby". "Hi, there!". She was obviously enjoying Colin's reaction. As she examined she pointed out Colin's developmental level to the parents:

> I always like to check the hips, because sometimes there are hidden problems....At this stage they don't have much strength in the neck - you notice the head's still falling back....It takes a while for them to get good control of their eye muscles and to follow real well. Has he had things to look at in his crib at all?

When the mother told her that Colin was still in a cradle, Lois added some anticipatory guidance.

> I see. When you do move him to a crib, pictures you can cut out of a magazine are interesting to them...the more things they can look at just while they're lying in their cribs - the more they practice using their eyes. It's also a good thing to place them on their tummies because they do practice lifting their heads. (Colin gurgles).

Lois went on to check Colin's feeding habits, but mother did not prove to be a sound historian and Lois was left not knowing exactly how much the child was taking. When she charted the height and weight following this dialogue with the mother she commented:

> He's just about average for his height, and just a bit below what you would expect for his weight. Ummm...the next needle won't be due for two months, but perhaps, you might want to come back in two weeks to have him weighed.

Mrs. Roddick:	Is he overweight - is that what you're saying.
Lois:	No, on this graph here (shows mother), the dark line shows the average for boys - as they get older the line moves along here - and he falls right here for his weight - which is a little below the dark line - which means he's a little below average for his age.
Mrs. Roddick:	Is it too light or too heavy?
Lois:	A bit too light - but if you come back in a couple of weeks we can check how he's doing.
Mrs. Roddick:	Well, shall I give him pablum then?

Lois: No, I'd just maybe see if he'll take a little more milk....We are advising that babies, especially if they are on a formula like Similac, really don't need it, [solids] until they're at least three to four months old. The milk provides everything they pretty well need - it has vitamins as well.

Mrs. Roddick: You should listen to my mother and grandmother!

Lois: Well, yeah.

Mrs. Roddick: "Well, he needs some food" (imitates).

Lois: Yes, well things have changed since they were bringing up their families. It's largely because we didn't have these new formulas then. They are as close to breast milk as possible, and do give the baby what he needs. If he seems hungry, I'd suggest trying more milk rather than giving solids.

Mrs. Roddick: I thought he was drinking too much. I guess you're not drinking enough are you? (warm tone of voice).

Lois remarked that Colin was a very active baby and Mrs. Roddick told her, "We like to play with him". While she was conversing with the parents, Lois had re-measured Colin's head circumference (this is done by the clerk when the baby is weighed).

> We'll keep an eye on this head measurement too, it's just at the top of the scale for his age, it may be he has a big head and as long as growth is steady there is nothing to worry about...if you do bring him back in two weeks we can recheck that too.

Neither parent reacted to the comment, Mrs. Roddick going on to speak of the way Colin settled down when they played with him. Mrs. Roddick seemed to have trouble grasping the fact that Lois felt Colin was underweight and she had to explain the problem several times. While she made it clear that Pablum was unnecessary, she did not say, "don't give it", but rather, "I would suggest trying more milk rather than giving solids". This is in keeping with her belief that nurses should provide information, but respect the client's right to make up their own mind.

She did go into some detail as to why solids are not given as early today, so hopefully Mrs. Roddick could respond to her mother.

A little later in the visit, when Lois was preparing to give Colin his immunization, Mrs. Roddick again misunderstood what Lois said:

Lois:	We can start Colin today on this immunization and we give four things the first day - three of them are in the needle, whooping cough, diphtheria and tetanus.
Mrs. Roddick:	Three needles?
Lois:	No, just one needle.
Mrs. Roddick:	I was going to say, he won't sit there for three needles (laughs).
Lois:	I don't think we'd find enough spots in a fellow like this.

Following the injection Mrs. Roddick held Colin close to her, "It's okay, it's okay". She kissed the baby and then offered him his bottle, "There, like a drink, make you all better". Colin started to suck vigorously on the bottle. Lois arranged the date of the next immunization with the parents. Father picked up the bag with bottles and diapers as they left. Following the visit Lois reflected on the situation:

> The head circumference was just above the 95 percentile - I'll wait, but want to see the baby soon to see what's happening. There was an article that suggested the best measurement of intercranial problems was head circumferences, you wouldn't get any signs of delays in development until things were well advanced...which I was suprised at really. If babies had large heads I'd feel not too badly if they were following a normal growth rate...but it seemed in the article you needed to be concerned.

Here Lois shows that she integrates recently acquired knowledge into her practice and that she was, as she believed, alert to potential problems, because of the exposure to the latest theory she got in her position as infant-pre-school nurse. She was also concerned about the mother's abilities to care for the child.

> It seemed to be hard to get her to say what the baby was taking - it sounded like he was probably taking a reasonable amount, but he didn't seem to have been growing that well, he looked rather thin. She seems rather young...she might not have a lot of experience to have sound judgement on feeding and baby care. For instance, where the elastic had been, it looked like it must have been very tight... maybe she needs extra help with aspects of care that with an experienced mother you wouldn't think about. With her being so young...and the father looked it too - she may need extra support. I certainly got a good feeling about the way she was handling the baby - both parents seemed to enjoy him - he didn't say much, but he watched what was happening.

Lois put a red sticker on the chart, she classified the baby as a potential risk because of the head circumference, but she was also concerned about the mother. Two days later the father called to say Colin had had to be admitted to hospital with diarrhoea and a fever, the evening following immunization. The doctor had suggested it might be an allergic reaction to the egg yolk in the vaccine. Lois explained that vaccines did not contain egg yolk. The parents did not return to the clinic and as their home was within Central Clinic's home visiting area, the nurses from that clinic were asked to follow this family. In this instance the parental behaviour did not suggest that Colin's injury was related to physical abuse, but Lois did feel that it could be related to inexperience on the part of the mother and that therefore the family needed some supervision from the nurse.

One other visit caused Lois to assess the situation carefully because of evidence of physical trauma to a child. A single mother, on welfare came to clinic with her eighteen month old son, Jack, who had been brought for a DDST and immunization. When Jack came in he had a black eye and a bruise on his cheekbone. His mother explained:

> He climbs up and down on everything. He walked into an open cupboard and bruised his eye - it caught him on the bone under his eyebrow. Then he fell over and banged his cheek on a chair leg. (27/10/79)

As Lois talked to the mother about Jack's development, he played around the room. He chattered away to himself and seemed independent of his mother. Ater a while he became bored and came up to her demanding to be picked up - she made room for him on her lap. Following the visit Lois commented:

> A single mother on welfare, you think about the bruises -but the child was independent, he showed no signs of being insecure and when he went to mother, she responded positively and made room for him. I felt satisfied that her story was true. He did have a line down the centre of that bruise on his eye.

Lois put together her observations made during the visit, with her knowledge of child behavior, to arrive at the conclusion that there was little probablity that the child had obtained his injuries through abuse. However, she was aware of the possibility and checked out the situation as she observed the child and spoke to the mother.

Summary

When Lois visits with mothers and their babies in clinic she shows herself to be constantly alert for deviations in physical, psychological or social behaviours. Her focus on case-finding tends to orient her approach in such a way that she believes the family has potential problems unless it is proven otherwise. She shows a strong identification with the agency but does not unquestionably accept the policies. She develops strategies for overcoming those that interfere with client care. Her own hesitancy in making initial home visits appears on occasion, to influence her decision on whether or not to follow up a client. While she sees multi-problem families, she is also involved with families whose problems are relatively short term and easily resolved. She expresses satisfaction with positive client response when she is able to give guidance and support to these families. Some clients fall into the area of secondary prevention, so that the ultimate outcome of the current presenting problem may be mitigated by circumstances beyond Lois' control. Lack of contact with social workers, breakdowns in communication within the clinic and difficulty in inter clinic communication create frustration in providing care for clients. Lois' concern for social problems is evident and she is alert to non-verbal as well as verbal cues in obtaining information. There is evidence of application of theoretical knowledge but her own life experiences also play a part in her evaluation of the clients' situation. Despite Lois' conviction that there was need for group teaching she experienced frustration as clients did not attend scheduled sessions. In one instance this appeared due in part to context rather than client motivation.

Lois' Perspectives of Nursing

The three dimensions of Lois' perspective of nursing, her definition of the situation, the actions and activities she engaged in as a result of her definitions and the criteria of judgement that she utilized will now be presented.

Definition of the Situation

Lois believed that the major purpose of public health was to prevent illness and crises. She believed that case-finding of families or individuals who were at risk was essential for achieving this goal. Lois saw the population she worked with as being essentially healthy but identified young, unmarried mothers as being a particularly vulnerable group, essentially isolated from the community and with an increased potential for child abuse or child neglect. She acknowledged that it was the client's right to make decisions and manage their own lives. The nurse's major role was in educating and supporting problem families. The nurse provided information in areas where she had expertise so clients could make informed decisions for themselves. Lois also saw herself as interested in the social aspect of clients problems and attributed this in part to her own life experience and in part to the emphasis in her educational programme. She saw it as satisfying to help young mothers who were having difficulty coping, as a few nurse-client interventions could make a big difference in increasing the mother's ability to cope with the baby. Lois also felt group teaching to be important and believed that more could be accomplished if some group education were to be established. Lois' model of nursing was based on case-finding, with education being the major nursing intervention once potential or actual problems were identified. Lois saw herself as independent and able to make her own decsions. She enjoyed working with mothers and young babies. Lois believed that for nursing intervention to be effective it was important that the client see the nurse as a knowledgeable professional worker.

Lois' Nursing Activities

In Lois' interaction with her clients her application of her beliefs to her actions was apparent. Lois did encounter many well mothers who were insecure and she demonstrated her ability to listen and support these clients. She provided advice but allowed them to make their own decisions. If a client had already made a decision regarding child care, she supported their action when possible, weighing agency guidelines and her theoretical knowledge of optimal practices against the child's development and health status. She was particularly aware of the role of culture in influencing a mother's decisions. This was compatible with her belief that it is the client's right to make decisions which affect their own lives. Lois was careful not to offer advice until she had ascertained the mother's current level of knowledge and course of action. She used the guidelines on advice for treatment of cradle-cap, for example, to develop the content of her questions, to determine the mother's activities. Lois used both verbal and non-verbal cues to assess potential social problems and showed herself to be alert to minor physical deviations which she was careful to note in her records so they could be rechecked at subsequent visits. Her recording of her findings did provide a basis for continuity of care in areas where she detected potential problems. While Lois sees herself as independent in her ability to make decisions regarding client care, communication breakdowns between agencies or within the agency still acted as impediments to care. She, personally, did a great deal to ensure smooth communication about clients within the clinic. When she checked records she made referrals from the clinic nurse to the district nurse and contacted other agencies to make appropriate referrals to obtain additional information. This function was related to her job as infant-preschool nurse but it was also one that Lois herself saw as important in providing continuity of care for clients. Lois also had an up to date theoretical base for her practice which she used in assessing clients. She also acted as a resource for other nurses. However, if she was unsure as to the nature of a specific client problem, she herself utilized colleagues or other resource persons in finding a solution. Lois' priorities were in part based on the expectations of her position in the agency, that she visit all families that have newborn considered to be at risk because of prematurity, illness in the newborn period, or multiple birth. Thus much of her nursing fell into the realm of secondary prevention, she therefore tended to assume the family had a problem until she judged it to be otherwise. Lois showed some hesitation in initiating home visits to clients she saw in clinic even when she felt it to be advisable in terms of the need for further nursing intervention. She said she found making an initial home visit difficult and this may be reflected in her hesitation to suggest a visit to the client. Lois showed herself to be responsive to the needs of single mothers but her own experience caused her to question the wisdom of young mothers keeping their babies. She felt that social workers did not help their clients identify the potential problems. Nurses then had to guide and support the mothers with problems related to immediate child care, but did not have the resources to help these clients become competent mothers given their own immaturity and childhood background. Because Lois also worked with prospective adoptive parents, who she saw as able to offer a stable home to a child, this situation created conflict for Lois. Lois believed group teaching could be effective but her attempts to work with post partum mothers in group situations were largely unsuccessful. In two instances only the highly motivated mothers attended, and these were not the group she perceived as needing education. In the other instance the context of the situation did not encourage clients to attend. The clients who did attend the classes appeared to be interested and appreciative of the sessions. Lois' vicarious enjoyment of the babies was evident in her interactions with them in the clinic setting.

Criteria of Judgement

In nurse-client interactions Lois assessed the level of family functioning by utilizing information on the family support system, the client's anxiety level, what information she obtained on nutritional patterns and her observation of physical care. In maternal-newborn situations she assessed the level of maternal functioning, which included how the mother handled the baby, her response to the baby's needs (and in particular his crying), how relaxed the mother appeared to be in the situation and the general physical appearance of the baby. It was evident when she assessed the gentleman who came for influenza protection that she utilized the first more general set of guidelines to assess his status and her application of the criteria for maternal function appeared to be consistent in both clinic and home situations.

When Lois assessed the client's anxiety level she indicated that she considered this within the context of the situation, she expected that a mother who had a child with a birth defect would be more anxious than one with a normal newborn for example.

In deciding to terminate contacts with a family Lois balanced the current level of coping ability with the need for support. If the client had plans made to see a physician she felt the child no longer needed physical supervision, but she would check at three months of age to see the mother had followed through with her plan. The state of Lois' own caseload also determined whether she terminated visits or made a return visit to a family who she judged to be coping but where the anxiety level was still high, available time was therefore a factor in setting priorities. The family assessment made at a first visit was critical as a basis for future plans.

Lois demonstrated that she was able to balance the mothers' actions, the agency guidelines and policies and the baby's state of health in making a decision on the advice that she gave. She had a strong identification with agency policies but did not accept them unquestionably when she believed them to be a disadvantage to the client.

In clinic Lois was constantly assessing the physical status of the child and while she might be judged as over cautious, on several occasions her caution was shown to be warranted. She frequently utilized an up to date knowledge base as a guide for making decisions and felt free to use other resource people in situations where she did not feel competent to make a decision.

Lois' model of nursing had five major elements: (1) a belief that the focus of public health nursing was to prevent illness and family crisis; (2) a belief that prevention was based on case-finding; (3) a belief that the client must respect the nurse as an informed professional for intervention to be effective; (4) a belief that the nurse is primarily an educator, who provides guidance and support for the client with procedures; (5) a belief that clients have the right to make their own decisions about their health and lifestyle. Lois' nursing activities and the criteria she employs to judge the situation are related to these elements. Lois' own convictions about the problems of single parenthood are strong but her reaction to young mothers keeping their babies is based on her belief that clients should be adequately informed by professionals so they can make decisions and she believes this is not happening. Her own personality appears to cause her to hang back and delay an intervention when in her professional judgement she feels it to be necessary. Her model had strong elements of case-finding but she also showed elements of a caring relationship in her respect for the clients' need to make their own decisions in order to develop themselves.

CHAPTER 9

COMPARISON OF FINDINGS, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

Summary

This study was designed to describe and explain four nurses' perspectives of nursing. For the purpose of the study a perspective was defined as being a set of interrelated beliefs, actions and judgements. The perspective of each individual nurse was presented at the end of each case-study in Chapters 5 - 8. While there have been studies that have examined specific aspects of the nurses' functions in a community setting, there was no evidence of any studies which examined the questions of how the nurse herself described her beliefs and how her beliefs influenced her nursing actions.

Given the basic assumptions of symbolic interaction and the need for descriptive data on nursing from the nurse's perspective it was judged appropriate to conduct an ethnographic study with the researcher being a participant observer in the situation. To catch the process by which the nurses encountered, interpreted and ordered their view of nursing, the researcher placed herself in the nurses' environment, took a limited role in nursing, administrative and social activities and observed the four nurses from as many vantage points as possible. This final chapter presents the comparison of the findings for each nurse, the conclusions, implications and recommendations.

Comparison of Findings

The study was developed around four exploratory questions. The questions are presented and the findings compared in this section. The exploratory questions were:

(1) What elements constitute each nurse's perspective of nursing in the practice setting?

(2) Which contextual variables outside and inside the situation of the nurse-client interaction influence each nurse's perspective of nursing?

(3) What are the assumptions that each nurse makes about clients and nursing intervention which support or are contrary to each nurse's perspective of nursing?

(4) How does each nurse synthesize the various types of information about the client and his/her background into her perspective of nursing?.

Question 1. What elements constitute each nurse's perspective of nursing?

The major elements which constituted each nurse's perspective of nursing are summarized in Table 9.1. Carol believed promotion of health to be the major goal of the community health nurse, Ruth saw prevention of illness as the goal but identified health promotion as a facet of prevention. Kate and Lois both believed that the focus was on prevention of illness but Lois was concerned that the social ills of society resulted in much of the nursing intervention being in the area of secondary prevention. Lois cared for all children who had been prematurely born or who had been in neonatal intensive care units, so many of her clients had newborns who had already experienced physical

Table 9.1

The Major Elements of Each Nurse's Perspective of Nursing

Carol	Ruth	Kate	Lois
A healthy lifestyle is the ultimate goal for the clients: that is health promotion.	The focus of public health nursing is the prevention of physical and mental illness.	The focus of public health nursing is the prevention of illness.	The focus of public health is to prevent illness and family crises.
The nurse helps the clients to identify problems and make decisions to achieve a healthy lifestyle.	Health promotion is a part of prevention.	The nurse must focus on the client's identified priorities or motivate clients to provide alternate concerns.	Prevention is based on case-finding.
There must be mutual respect between nurse and client for her goal to be achieved.	That the means of accomplishing prevention is through client education.	Respect is generated between the nurse and client when openness exists.	The client must respect the nurse as an informed professional for intervention to be effective.
The nurse is an informed facilitator who guides the client toward a healthy lifestyle.	The nurse provides the clients with information so they can make informed choices.	Clients are mainly concerned with basic needs related to survival.	The nurse is primarily an educator who provides guidance and support for the client with problems.
The client is capable of becoming healthier and so independent of professional services.	For education to be successful there must be mutual respect between the nurse and the client.	Co-operation between professionals is essential for preventive care.	Clients have the right to make their own decisions about their health and lifestyle.

illness. Single mothers also figured prominently amongst her clients as the premature birth rate was higher in this group. As single mothers generally had many social problems her concern with secondary, rather than primary prevention was reinforced.

Each of the major informants also gave priority to a different aspect of the nurse's role. Carol believed her goal to be to help the client achieve a healthier lifestyle by helping them to identify their own health problems, select alternate courses of action and make decisions about the course they wished to take. She believed that success was related to mutual respect between the nurse and the client and that the nurse acted as an informed facilitator who guided the client toward the desired goal.

Ruth saw health education to be critical to prevention. She believed that if clients were provided with information they could then select a healthier lifestyle. She saw health promotion as an off-shoot of prevention. The nurse was an informed professional who gave the client information based on her assessment of the client's level of knowledge and accuracy of information. Ruth, too, felt mutual respect between nurse and client was essential for successful interaction.

Kate saw the focus of public health nursing to be prevention of illness. The nurse's role was to focus on the client's identified priorities or to motivate the client to accept other concerns as a priority. She believed respect would be generated between the nurse and the client when openness existed between them. She also believed that clients in her area were mainly concerned with the basic physical needs related to survival and identified a gap between their needs and agency programmes. Kate was concerned with the need for teamwork among professionals in order to provide preventive care.

Lois' goal for nursing was case-finding. Lois saw the population in the community as essentially well individuals thus case-finding led to the identification of at risk families. The nurse could then put her effort into preventing problems developing in this group. Lois saw client education as one way of preventing primary and secondary problems. Her model of nursing was based on the need to listen to the client and to provide guidance and support for the client. Lois believed that ultimately clients have to make their own decisions about their health and lifestyle. While Lois' primary focus was case-finding compared to Carol's focus on decision making, the two held common beliefs on the clients' right to decide for themselves and in many instances their mode of interaction with the clients was similar with regard to their provision of guidance and support.

While there were differences in the perspectives of all four major informants, there were also similarities with the perspectives of their colleagues (Chapter 4). Elements of all their perspectives were reflected by at least one other colleague, however the organization of the elements varied from nurse to nurse.

The finding that all the informants, Carol, Ruth, Kate, Lois and their colleagues, differed on the goals and priorities of public health nursing is not surprising, as clients and situations that the nurse encounters are many and varied. In a review of the English literature on health visiting, Smith (1976) revealed there was a divergence of opinion on what the priorities were within the role. Functions of health visitors included prevention, health education, family planning, social counselling and primary care. Yet there was no consensus in the literature on what was, or should be, the primary function. Given the similarity of the roles of the health visitor and community health nurse established in Chapter 2 the lack of agreement in priorities is not unique to the nurses in this study.

Question 2. Which contextual variables outside and inside the situation of the nurse-client interaction influence each nurse's perspective of nursing?

Contextual Variables Outside the Nurse-Client Interaction

Several factors outside the nurse-client visit seemed to influence the nurses' perspectives of nursing. First their own life experience strongly influenced their belief about their primary function as a nurse. Second their perception of agency policies and guidelines influenced their actions. Finally, the climate within the clinic and the time available for client care and the influence of other agencies or agents all modified the way in which they nursed.

For Carol decision making was a very important factor in her own lifestyle, she spoke of this frequently. It became central to her goal for nursing, to help clients achieve a better life by becoming proficient at identifying problems and making decisions. Her major source of frustration was clients who did not want to change their lifestyle when Carol saw it as being untenable. However, for Carol the fact that the client made a decision was more important than the decision that was made and so this, at times, prevented conflict in her beliefs. Much of

Carol's philosophy reflected the goals of the values, attitude and practice workshop, yet it was evident that the roots of her belief went further back into her own life experience, so it appeared likely that the educational programme reinforced her beliefs rather than generated new ones.

Ruth believed education to be an important part of her professional development but she also saw her nursing education programme as strongly influencing her belief that prevention was the core of community health nursing. She had a commitment to her work that was evident in the time she spent in prenatal teaching and committee activities. Ruth allotted time to work and time to her home life and saw herself as giving her full energy to both. Even when she was sick, on one occasion, Ruth was conscientious about teaching her clients. Her view of herself as a conscientious and organized individual was reflected in her work.

Kate saw herself as giving priority to those things that interested her outside of nursing. When she approached clients she did so in the belief that they would give priority to the things that interested them and so she looked for the individual needs which were the priority for the client. Her hospital experience had made her believe that prevention of illness was important. Her concern with exercise and nutrition as means of illness prevention became evident in her work in the schools, which again reflected her own personal interests in nutrition and fitness. Kate also reflects the goals of the values, attitudes and practice workshop, but again her beliefs were reinforced rather than generated from the programme.

Lois focussed much of her concern on the single parent. This was related to the fact that she was widowed when her daughter was small. In particular she felt these young mothers were not made aware of the difficulties they would encounter by the social workers. Her role as infant pre-school nurse also influenced the way she viewed public health nursing, and she gave priority to case-finding. Her model of nursing was closer to a medical model in that she looked for problems. For while she recognized that the population was primarily a well one, she believed that her target population was the families identified as having potential problems. Lois' view that public health nursing should be prevention oriented was based on her work with children with psychiatric problems. She viewed early support and guidance of the mother as critical factors in preventing later emotional maladjustment. However, while she put emphasis on prompt and concentrated input with one new mother who found herself unable to cope with a new baby at other times she delayed visiting or spaced out her follow-up. The positive response of the mothers was rewarding to Lois and reinforced her belief in the value of nursing intervention.

While the agency did not formally have its programmes ordered in terms of priority, all three nurses who visited schools saw them as a primary responsibility. Within the schools the priorities were the immunization and screening programmes. The paper work involved in these programmes was a major source of frustation as it was seen as detracting from more important nursing activities. In Kate's case this also included home visits to follow-up on problems she encountered with children in the school.

Guidelines for the conduct of a visit did shape the questions asked by the nurses and provided a common structure for the post natal home visit and the regularly scheduled well-child visits. The advice the nurses gave was also heavily influenced by the guidelines. However, the nurses did treat them as guidelines and weighed client needs against the suggested instruction before they utilized the information.

Policies were generally accepted by the nurses because they saw themselves as having input into their formulation. Even so, two policies created conflict with their perspectives of nursing; one of these was the policy which prohibited the nurses advising the mothers on specific medications for relief of fever, the second was a policy which restricted the nurses from telling a client his/her blood pressure. Both policies were viewed by the nurses as imposed by the medical officer. Lois felt that in enforcing the policy he was placating medical colleagues instead of explaining to them the role of the nurse in teaching clients. In that all nurses viewed themselves as independent this was considered an infringement on their right to make decisions about client care. As all four nurses believed that prevention was based on informing the client of his lifestyle choices, not telling the clients their blood pressure readings violated this principle and also precluded teaching. The nurses developed their own mechanism for handling these policies. Kate refused to take blood pressures, Lois called the individual physicians and Carol either called the physician or talked to the client, if she knew they already knew their blood pressure was elevated. With medications the approach was generally to check what the mother used and if she had no information to tell her the range of medications available. Thus the nurses developed mechanisms for circumventing policies which were in conflict with their perspective.

One situation that created some difficulty for the nurses was the client who attended clinic but who actually lived in another clinic's area. If a home visit was required this was supposedly carried out by the nurse in whose district the client lived. In one case this resulted in an urgent follow-up visit being delayed due to failure in communications between the two clinics, the birth notice being sent over to Greenfield without the home visit having been done by the primary clinic. In the second instance Lois was concerned about a mother-child interaction but the mother again lived outside the area of Greenfield Clinic. Finally the client was assigned to a student and when this fell through Lois felt able to visit to explain why the student could not come. Visiting across clinic areas was not viewed as an approved practice by the nurses and even visiting across districts was not seen as acceptable by all the nurses. One nurse in particular was seen as possessive of "her" territory. This restriction on client visiting again reflects on the nurse's view of herself as being an independent worker able to make decisions on the actions she feels to be in the best interests of the client. This dilemma was also evident in inter-agency situations.

In providing care for clients the nurse must frequently co-operate with other professionals. In the schools she is dependent on input from the principal, the counsellor and individual teachers if she is to identify children with potential health problems. In the area covered by Greenfield Clinic many families were in contact with social workers, workers from child protection, or mental health workers, to name the most common. Most families also took their children to a family doctor and some also went to a pediatrician. The nurses thus had to work as part of a team of workers without having much opportunity for contact with other members of that team.

Within the schools the tone set by the principal affected the role the nurse was able to play. Ruth found this in her work at Aviemore and Helston. In one school the principal relied on the psychologist and school board referral services, with subsequent delays in intervention. In the second school the principal and counsellor held conferences with the nurse to determine the most appropriate route to take. Kate had worked hard with the teachers at Snowdon to establish effective teamwork as a strategy for identifying children with problems given the constraints in the time she had available to spend in the school. The greater the amount of time spent in the school by the nurse the more she appeared to be used by the staff. Carol claimed that it had taken two years for her to become established and known by the staff at Shipton School.

All four nurses found liaison with social workers to be frustrating. They recognized that social workers had an overload of clients and Ruth said there were times when she would retain a client if she felt her intervention could prevent a crisis because the situation was not sufficiently critical for the case to be a priority on the social worker's list, she thus extended her role beyond the normally perceived limits. Obtaining information from social workers was time consuming in part because they were so hard to contact. Carol might visit a client and have no idea how many workers were already involved with a family. Thus care of multiproblem families was unco-ordinated and the best the nurse could do might be to see the child was washed and fed adequately. The nurses felt that time spent tracing families might be avoidable if there was more cooperation among agencies. For example Carol was following one girl, who was housed by the social welfare department, but after she had been unable to make contact with the client over a period of several weeks she was unable to contact the social worker to find the client's whereabouts. Carol was also anxious to find out whether the mother now had her two year old at home, as she had recently been to court to try to get a custody order revoked. Carol was frustrated as she identified this mother as needing supervision in the care of her child, yet was unable to contact her.

Kate had difficulty in working with one group of medical practitioners in her area. Agency policy required her to refer clients to their own doctor if she identified a medical problem. She felt that the doctors in this practice did not carry out a thorough investigation of patients problems and had evidence to support this. Teachers too, had commented on the inadequate care they felt they had received from these practitioners. The ethics of the situation were such that Kate could only suggest parents might like to see the clinic doctor or seek a second opinion if they were dissatisfied with the information they had received. The nurse's role is one of persuasion so Kate was in a double bind as she could do nothing further if the client did not accept her suggestion. She did not give up easily however, and with one child in the school who was grossly overweight, she enlisted the aid of the teacher and ultimately persuaded the mother to get a second opinion which resulted in medical treatment for the child.

Lack of services also detracted from the nurse's ability to ensure that clients had adequate care. Ruth knew of several potential mental health problems but due to a lack of preventive services, two children became psychotic before help could be obtained for them. Kate, Carol and Lois all encountered incidents that violated the nurses' beliefs that prevention of illness or crisis was a realistic goal because while they identified the problems associated support services were perceived as inadequate.

This area of co-operation with other professionals is one that infringes on the nurse's view of herself as an autonomous worker, able to make independent decisions in the best interests of her client. As a consequence all four nurses in the study identified working with some principals and teachers and in working with social workers as a source of frustration in the job.

The three nurses who worked on the district all felt a need for a support system within the clinic. Lois did not identify this need to the same extent but she did not work in isolation as did the district nurses. Neither Ruth, Kate nor Carol saw the administrative system within the clinic as supportive but Ruth and Carol used their peer group for support. Kate, who was the least experienced nurse in the group, was uneasy about her priorities for client care and would have liked administrative assurance as well as peer group approval that her beliefs about nursing were compatible with those of the agency. Because she felt unsupported in the clinic she tended to rely on one of her schools for feedback on her effectiveness as a nurse and for social interaction. While the nurses said that the friction in line-staff relationships did not affect their interaction with clients, they did see it decreasing the resources available to them to help with problem clients and reducing the energy available for nursing intervention. As much of the nurse-client contact was on a one visit basis, rather than prolonged, there was little feedback for the nurses on the effectiveness of their care. This lack of feedback, either from the clients themselves, or from the supervisor, did not provide the nurses with an opportunity to identify weaknesses in the nurse-client framework from which they operated.

Contextual Variables Internal to the Nurse-Client Interaction

Within the nurse-client interaction several variables influenced the nursing perspective. One critical influence was the client as a person. Within the nurses' districts clients tended to be fairly homogeneous with regard to social background and economic status. However, there was throughout the area served by the clinic a wide mixture of ethnic and cultural backgrounds. While all four nurses saw the provision of information as critical in working with clients, the level at which this was presented had to be constantly tempered by the educational level and level of understanding of English held by the client. The nurses too worked with clients of a wide age range, so maturation and cognitive development again influenced the informational input the nurse provided. In one day Ruth taught nutrition to kindergarten children and in the evening to prospective parents at prenatal classes. This reinforced the view that the nurse in the community must be flexible and also the belief in the importance of meeting individual needs.

While the nurses recognized and accepted cultural values that differed from their own, they did not appear to recognize or accept differences in the client's health values when they conflicted with their own beliefs. Thus Carol was frustrated with a client who did not wish to change her lifestyle; Ruth was frustrated with a client who identified new knowledge but did not put it into action and Kate when a mother changed her behaviour, not because she believed in the change but because she viewed the nurse as an authority figure. Central to each instance of frustration was a clash of values. One activity the nurses all engaged in was developing a biography of the client. The effectiveness with which they developed the initial profile depended on their own skill level in questioning and their willingness to probe beyond the outer surface layer of the individual. Ruth and Lois appeared to be adept at questioning the client and Carol showed herself to be aware of the need to verify information with significant others. Kate was less adept at listening for cues and at using probe questions. It appeared that her own values interfered with her ability to obtain covert data. When it came to determining a course of action Carol, in keeping with her perspective, generally provided clients with a choice of action. With children this was not always effective, as adult preferences overruled those of the child, and the final solution was not discussed with the child. In clinic, too, there was more evidence of presentation of agency guidelines for feeding and child care and less evidence of consideration of client preferences. Ruth provided clients with detailed information, based on her assessment of their knowledge gaps, but due to lack of continuity of care, rarely assessed the effectiveness of her input. Kate did focus on the needs of the individual, tending therefore to concentrate on the overt needs the client presented. Lois used her data and her knowledge of deviations to look for potential physical emotional and social problems but also engaged in anticipatory guidance, that is giving clients information, which will decrease the likelihood of future crisis. Thus all nurses showed evidence of implementation of their beliefs in practice but the effectinvess with which they developed and utilized the client biography affected the effectiveness of the nursing intervention.

Each nurse showed her respect for the clients' rights to make decisions. They were all alert to the risks of undermining the mother's concept of herself as a caregiver, so balanced their guidance with her preselected actions. Kate, however, was not always able to utilize cues which would have helped her identify alternate priorities for her clients. At times information was also utilized at its face value by Carol, Ruth and Kate without thought of possible deeper meanings not openly verbalized by the client. Kate, too, tended to develop a mind-set once she had identified a problem and did not explore possible alternatives or seek clarification. This contrasts with Ruth, who believed it to be critical to obtain an adequate data base from which to teach and utilized many probing questions as she sought to determine the clients' level of understanding. The personalities of the four nurses also appeared to influence the ease with which they sought information or intervened. Carol and Ruth were comfortable questioning clients, Kate and Lois less comfortable. Kate and Lois also seemed reluctant to act in a way that might be perceived as intruding on the clients' privacy even when, using their nursing judgement, they could see intervention to be ultimately beneficial.

Another factor in the nurse-client interaction was the uniqueness of each situation. While the nurse might know the purpose of the visit, for example a post-partum follow-up, she could only guess at the probability that the mother would or would not be coping with the new baby. Usually the data base from which the nurses started was minimal and the data needed to assess the situation varied from observable concrete facts to covert information presented in what appeared to be social conversation. All the nurses recognized the importance of obtaining a data base but the skill of the four nurses in obtaining information varied considerably. In most instances the nurse had to respond to the client while she was still collecting data, so needed to retain several pieces of information consecutively. There is evidence that data must be processed both simultaneously and successively and if a nurse is unable to do this an inadequate assessment of the situation is obtained. Kate appeared to have most trouble in maintaining several lines of thought simultaneously but this may also have been because she identified a problem rapidly and then focussed on it. This was congruent with her belief that one must focus on the client's need and she saw the problem openly verbalized by the client as exemplifying this need. Carol's belief that you helped the client sort out where they were and then identify where they would like to be, encouraged a much wider range of data collection. Ruth also collected a wide base of data in the home, believing teaching to be based on an assessment of client need, however she narrowed her focus to the presented problem in clinic and did not enquire about possible social and cultural influences to the extent she did in the home. Two factors seemed to be operative here, the fact that the agency provided guidelines for the interview and the time constraints imposed by the appointment system.

Question 3. What are the assumptions about clients and nursing interventions which support or are contrary to each nurse's perspective of nursing?

Each nurse's model rested on at least one major underlying assumption. Carol assumed that all clients wanted a better life. In the district in which she worked she saw many clients with low self-esteem and she found herself becoming frustrated because the clients were inarticulate, and even when they identified the problems, (for example the young girl who was beaten by her boyfriend), they had no motivation to change. On the other hand, because Carol was satisfied with evidence of slight progress, she was able to accept the changes she saw in some families, such as Charles' progress toward talking of alcoholic counselling and obtaining a job. Another of Carol's assumptions was that the public health nurse dealt with the well individual and moved them further toward positive health. Yet, in her school work, she frequently saw children who were already in a crisis situation, so much of her work could be classified as restorative. Some families had multiple problems, so she was only able to resolve the immediate problem. While prevention (such as screening and immunization) and restoration were a major part of her work Carol was alert to areas where promotion of health was feasible and she kept this as her goal even when her immediate activities were diverted. Thus she maintained her perspective even though much of her nursing intervention seemed to contradict her beliefs about a well population and health promotion.

Ruth's major assumption was that providing clients with information would result in a change of behaviour. Generally, this concept was not challenged as there was little continuity of care, so Ruth did not see clients again to receive feedback on the effectiveness of her teaching. She sought feedback on prenatal classes indirectly, asking clients what they had liked or disliked about classes they attended but these were not necessarily classes she taught, therefore the feedback did not reflect on her directly. The middle class nature of the district in which she worked tended to support an information giving approach, in that clients were interested in health and child development. Ruth was frustrated by a client who acquired knowledge but did not act on it, she did not however appear to consider the factor of motiviation, or question her assumption that given information a client would change the behaviour Ruth saw as undesirable.

Kate assumed that all clients had needs that they could place in order of priority and that they could overtly express these needs. Her model of intervention was based on a response to individual needs. Kate got into difficulties with this approach because many of her clients were not highly verbal about their problems and also because she did not obtain sufficient information to determine their needs. Her belief that clients would only act when the need was a priority for them was demonstrated, by the failure of clients in her area to come for immunization, even when aware of the service provided. The client whom she visited because her child came to school dirty changed her behaviour even though she subsequently told the teacher the child had never left home dirty. This supported Kate's belief that only when the client saw the need for a change in behaviour would that change be successful. Kate's assumption that most mothers in the area were young, on social welfare and that their concerns were vested in feeding and giving basic care to the child, was supported by the clients she saw at home and in the clinic. Children in school also had problems related to inadequate clothing and this too reinforced her assumptions about the economic status of her clients.

Lois differed from the other nurses in that her perspective was oriented to problems rather than to clients. She assumed that all families had problems until proven otherwise. Given the nature of her clientele, all babies who had been in intensive care, who were prematurely born or who were twins or triplets, this was a reasonable assumption. Her job too made her the resource person in clinic for all infant and preschool problems, so that she was up to date on the latest literature on screening for abnormal conditions. Given the conditions of the job, Lois' focus on case-finding was legitimized and her approach reinforced in the situation.

Lois and Kate both assumed when they became community health nurses that they would be in a position to prevent disease. For Lois treating mental illness in a preschooler was intervening too late. For Kate medical and surgical treatment of diseases associated with lifestyle factors, such as cardiovascular disease, should be preventable. Lois found that with her clients intervention was still too late. She was faced with girls who were unmarried, with a history of many years of being a social misfit, now attempting to mother a new baby. She was only able to solve immediate problems of caring for the newborn and was forced to reflect on the role of societal values as a cause of crisis. She thought primary programmes in sexuality were inadequate and that support services for follow-up of the mother and baby were inadequate, but ended up questioning whether preventive programmes would be of use given the current societal values. Lois was faced with a situation that shook her assumption that health problems should be preventable. Kate, on the other hand, was able to identify children with potential health problems due to obesity and had some success in referring children for counselling or medical help. Thus her assumption that the nurse can play a role in the prevention of disease was reinforced.

Question 4. How does each nurse synthesize the various types of information about the client and his/her background into her perspective of nursing?

Carol's perspective centered on her belief that a healthy lifestyle is the ultimate goal for clients. Ruth, Kate and Lois all saw prevention of illness and social or emotional crisis as being their goal. As all four nurses worked in their district they took into consideration the social, economic, cultural, developmental and educational level of their clients in making decisions and appropriate interventions. The nurses all expected that the clients would be co-operative. When Carol found clients who were not accepting of help, she used her knowledge of the district to try to explain the clients behaviour. The nurses therefore synthesized the information about client background and behaviour through the process of self-indication (Cf. Chapter 1). They showed evidence that they pieced the information together and used it to guide their actions, taking into account varied information and interpreting its significance for prospective action. Ruth guided her information giving activities by interpreting the clients current level of knowledge, current understanding of English or developmental level. Kate guided her actions by intepreting the clients priorities and Lois by synthesizing information on the general well-being of clients and therefore her assessment of the presence or absence of a problem. Kate recognized that the clients in her area had to struggle to provide food and shelter for themselves and their families, and recognized that they would not be ready to work on agency goals related to child development and safety and she showed evidence of using their background when selecting interventions for children in the school.

In selecting priorities within the work situation the nurses all ranked home visits to mothers with new babies at the top of their list. They believed the first two weeks at home to be the most vulnerable for these clients and to prevent crisis developing early intervention was seen as critical. Prevention of crises was compatible for Carol with a model of health promotion because if the client is in a crisis she is at less than zero functioning on Carol's health scale.

All four nurses utilized the guidelines for evaluating maternal newborn behaviour as one way of gathering data on the clients. At the onset they had difficulty verbalizing the criteria they used to assess family function, but it became evident that they used a wide variety of verbal and non-verbal cues, how the mother spoke of the child, the type of concerns she expressed, her handling of the baby and the physical appearance of the child were all used to assess function. Carol differentiated between neatness and cleanliness, explaining that with several children a house might not be neat, but generally was clean, so in home visits surroundings were used to build a composite picture of the family.

The process of obtaining data and synthesizing it into a biography of the client was complex. Presenting data, for example weight loss, might only be a symptom of the real problem. Thus problems frequently dealt with unknown parameters and these had to be identified before the nurse could devise a plan of action. Polya (1957) speaks of this type of approach as the problem-to-find. The alternative mode is to look at problems as problems-to-solve where the problem is known, hypotheses can be formed and either proven or disproven. Problems-to-find are more akin to the mode the detective must use in solving a case, he collects clues, devises a plan to link the unknown to the data, checks the plan for adequacy and ultimately arrives at the solution. Carol's work with the Catelli family and Lois involvement with Richard and his family demonstrated the use of this type of problem solving strategy. Kate tended to form early hypotheses on problems, this early closure led to rejection of subsequent clues which could have redirected her thinking to other possible alternatives. Ruth collected a great deal of information but tended to synthesize this at a superficial level which placed her focus on the overt problems expressed by the client.

Lois analyzed information in a different manner to the other nurses, in that she looked for underlying significance. She was constantly alert to the possibility of birth defects, she was up to date on the latest research and current writing in the field, so tended to see minor irregularities, such as alignment of buttock creases in relation to hip dislocation, as potential problems more frequently than did the other nurses. She considered the anxiety level of the mother as a crucial factor in deciding whether or not she would make a return visit to the home. But she also considered anxiety level in relation to the degree of problem experienced by the child. This reinforced her belief in the case-finding approach she embraced but she also recognized the mother and child who did not appear to have problems and seemed to be adjusting satisfactorily to each other.

Respect between client and nurse was important for all four informants. Carol can accept being turned away from a house by a client, but takes into consideration the possible causes of that refusal. She knows that in her district many social problems exist and that this means that multiple workers may be involved with the client. However she would have different concerns if a client in her new district refused to admit her because she has assessed them to be middle class professionals relatively free of social problems. To date she has no evidence which would make her question this perception. When Carol moved to Redfield clinic she learnt it was inappropriate to visit without an appointment whereas Kate recognized that it was appropriate to "drop in" in her area at Greenfield. Here both nurses used their knowledge of the culture of their districts to arrive at their perspective of what was acceptable behaviour on the part of the nurse in a given district. For Lois respect was based on the client's recognition of her as a knowledgeable professional and she looked for evidence of this; whereas Kate believed respect was built on honesty and trust and was upset when she perceived this as lacking between herself and one client. On the whole the nurses' observations of the clients' behaviour reinforced their respective notions of respect.

Central to three of the nurses' beliefs was the notion that the primary role of the community health nurse was prevention. For Kate and Ruth the clients they saw reinforced this belief, as they immunized, screened or found families with health related problems. Lois was perturbed because she saw clients as having deep rooted social problems. She had moved into the community with the idea that mental illness might be preventable by early intervention in the maternal-newborn cycle only to find that many mothers had problems that dated back to their own childhood. She was left wondering whether the cycle could be broken. Carol had a belief in health promotion and despite the fact that many of her clients needed nursing intervention because they had health problems, she maintained her belief in health as the optimal goal. The model Carol worked with encouraged her to accept evidence of minimal progress as a sign of positive growth and so she was able to maintain her beliefs when the evidence from her clients' health status suggested that this perspective was idealistic rather than realistic.

Conclusions Relating to the Nurses' Perspectives

It would be inappropriate to generalize from this series of four case studies but the following postulates appear to be significant in terms of the perspectives of nursing of these four nurses:

- nursing is individualistic to each nurse.
- each nurse has in mind a theoretical model of nursing which she articulates, and which she uses to guide her practice (Table 9.2).
- while all models have some common elements the organizational relationships are unique to the individual.
- the primary influence on the elements included within each model are the nurse's own lifestyle experience and priorities.
- once a perspective has developed it appears that outside forces have a minimal effect on changing this perspective.

Table 9.2

A Comparison of the Framework of Beliefs Utilized by the Four Major Informants to Guide Their Nursing Actions

Criterion Variable	Components of the Nursing Models			
	Carol	Ruth	Kate	Lois
Goal of Public Health	Health Promotion.	Prevention of illness and promotion of health.	Prevention of illness.	Prevention of illness and crises.
Goal of Nursing	To help the client achieve a healthier lifestyle.	To educate the client so potential problems may be prevented.	To identify client needs and intervene to prevent potential problems.	To detect potential actual problems & institute preventive nursing measures.
The Client	Is motivated to improve actual lifestyle.	Has basic knowledge and is motivated to learn.	Has own priorities/needs which can be identified.	Has potential or actual problems that can be identified.
The Role of the Nurse	To help the client identify problems and make decisions about solutions.	To provide the client with information so a healthier lifestyle can be selected.	To identify client needs and provide information to improve their coping ability.	To identify potential problems and provide education, guidance and support or refer to other resources as needed.
Source of Client's Actual or Potential Problems	Social, Psychological Physical, circumstances.	Insufficient knowledge to anticipate or cope with problems or to make appropriate lifestyle choices.	Multi-problem families with social, psychological and physical problems plus lack of knowledge.	Secondary problems related to uncorrected primary problems or crisis. Potential physical or developmental crises.
Focus and Modes of Intervention	Collecting of data base. Action, interaction, reaction, transaction.	Collecting a database. Teaching the client.	Identifying the client needs. Teaching the client. Supporting the client. Negotiation with the client on priorities.	Collecting a database. Identifying potential or real problems. Guidance, counselling, referral.
Expected Results of Nursing Activity	Independence of the client from professional help.	Adoption of a healthier lifestyle, acceptance of measures to prevent illness.	Increased ability to cope with tasks and activities of daily living.	Prevention of crises of restoration of health if problem already exists.

- educational programmes may reinforce beliefs but it is probable they have only a minimal effect on changing pre-existing beliefs.
- agency guidelines and policies guide the direction of nursing action but where conflict with beliefs occur the nurses will devise means of circumventing the policies.
- while nurses are able to identify their own beliefs they do not recognize that frustration with clients may be vested in values conflict.
- nurses do not always have the skills and/or knowledge needed to operationalize their internalized beliefs.
- the nursing situation is complex and many problems may be of a problem-to-find rather than a problem-to-solve nature.
- there is a lack of feedback for the nurses from the employers, the client or their peers on their effectiveness in nurse-client interventions. Thus nurses do not recognize the strengths and weaknesses of their models.
- contradictions of the nurse's perspectives by doctors and social workers are off-set by a lack of face to face contact.
- the relative isolation of the nurse at work and the stressful nature of care giving means that the nurse needs a support system within the work situation.

Conclusions Relating to the Study Method

The ethnographic approach used in this study was both feasible and useful for study of the interactions between nurses and clients. The strengths and weaknesses of the method as used in this study will be discussed.

The Role of the Observer

One of the purported difficulties of using the participant-observer role has been assessing the effect of a third party on the observed interaction. In this study the clients generally ignored the observer once the interaction with the nurse commenced and would often proceed to discuss topics which would normally be regarded as potentially embarassing. This concurs with Luker's (1978) findings when she observed health-visitor client interactions. In a similar situation Kratz (1975) found that the relationship was dyadic rather than triadic, the observer being viewed as one with the nurse. In this instance the introduction to the client emphasized the observer was a nurse-researcher.

One of the four major informants repeatedly expressed her feelings that the observer's presence inhibited her interaction with the client. There was evidence, however, to show that she was uncomfortable when any third party was present during an interview. It is probable that while the observer may have influenced her interaction there was not an overall distortion of the pattern of behaviour observed.

All four nurses used the researcher as a resource when interviewing clients. Informants said that if the researcher had not been present, or had not been viewed as as credible colleague, they would have sought help elsewhere. It was evident from patient's comments, notes on patient records and the behaviour of other nurses that consultation within the clinic was a common occurrence. Use of the observer as a resource person (and her role as nursing colleague) appeared to be part of a normal behaviour pattern. The process took time to establish and would not have beeen obvious if observations had been on a limited or intermittent basis.

Selection of Informants

The study used volunteers and the four major informants retained a strong commitment to the project throughout the study period. The attention they devoted to checking the final case-studies was evidence of this, as they even cross-checked the observers recording of their work week against their diaries. They also utilized social contacts even at coffee to keep the researcher up dated on clients, when they thought the information would be of interest. This continued information was often more enlightening than observed visits and would have been missed without prolonged contact.

Selection of Clients for Observation

Due to the appointment system in the clinic the nurses were unable to screen the clients they saw with the observer. In the schools also, screening of clients was not possible. On the other hand, in the home setting there was some pre-selection, so that a cross-section of clients may not have been observed. This pre-selection was offset, however, by emergency calls which upset the nurse's planned visits. When talking to all the nurses in the clinic about the types of clients they visited the observed situations appeared to be reasonably representative. From social conversations it was obvious that the type of client varied greatly depending on the district to which the nurse was assigned.

As the nurses have flexibilty in organizing their home visits, following each one for a two or three week period rather than one week at a time might have ensured better representation. However, this would have cut down on the variability of the situations observed in the schools. In this area a longer observation period (i.e. over the whole school year) would have been preferable, as the nurses claim they engage in more teaching activities in the latter portion of the school year.

Ethical Considerations

There were two major ethical considerations; obtaining the consent of the clients observed for study purposes, and the effects of observation on the client.

The major difficulty with obtaining consent was with the non-English speaking client. In the case of the Vietnamese family the observer's presence was explained through an interpreter but the decision was made prior to the interview that a tape-recorder would not be used. It was felt that unless the family really understood the purpose of the study the use of a tape recorder could have been misconstrued. In a second case, the nurse's concern regarding a family was such, that some observations on the visit were used. The conversation utilized in the study however related only to immunizations. While the researcher's presence had been explained, the family had such a poor command of English that if the conversation had included any personal matters it could not have been used. On two occasions nurses requested that the observer remain in the car while they made a visit. They believed the observer's presence would interfere with nursing care. Even so they gave the rationale for their decisions and openly discussed the visit following its completion. Ethically the researcher must respect the nurse's assessment that her presence might interfere with nursing care. One difficulty with this type of research is that the researcher must continually make decisions on the ethics of data collection and use throughout the study.

Many observations were made on the climate of the clinic. It was judged that these could prove harmful to participants and so a decision had to be made to exclude their use in this study. It is evident that despite the development of ethical guidelines to direct the study, the researcher's judgement is still needed to make situational decisions and that these must often be made independently.

Data Collection

There were no major difficulties in observing nurse-client interactions. Two clients declined to have the interview taped but had no hesitation in allowing the researcher to observe the interview and take notes.

Recording in the clinic did present some problem as background noises tended to obscure conversation. For example a child's cry had a higher decibel level than conversation. Thus some data were lost due to interference from background noise.

It was found necessary to make field notes on the nurse's assessment of home visits, as the interviews were held in the car. Also if the visit to the next client was made immediately information on several visits had to be retained simultaneously. Thus it was necessary to check field notes with the nurses to validate the recorded information as soon as possible, preferably the next day. In two instances the researcher had confused data on clients but by verifying the field notes with the nurse the misinformation was corrected. Data could also be cross-checked in social contacts and these proved to be valuable as some comments made in formal interviews could be clarified and cross-checked.

The original intent had been to interview the other nurses in the clinic before the study commenced. But the four major informants suggested it might be advisable to leave this until their colleagues were used to having the observer in the clinic. In retrospect this proved to be valuable advice as only one nurse declined to be interviewed and given the climate of the clinic the outcome would probably have been different if the interviews had been attempted before the observer had established rapport within the group.

Value of Prolonged and In-Depth Contact

If the role of a non-particpant observer had been used in this study nursing actions could still have been described but the rationale behind the actions would not have been understood. The informants frequently provided a logical explanation for actions which, on the surface, appeared inappropriate to the observer. An understanding of the complexity of the care required and the variety of situations in which the nurses must act only developed over time.

The post-visit interviews did have an effect on changing the nurses' behaviour. They would tend to make additions to their comments on the clients record following the interview. As the study progressed they became more articulate at describing the criteria they used to assess the client status during a visit.

As tapes were transcribed certain perceptions or observations needed to be clarified with individual informants. The continued social contacts, between periods of intense observation, allowed the researcher to carry out these checks with the nurses before details of client or visit were forgotten.

The greatest benefit of being a participant-observer was in being able to get immediate feedback from the nurse on her perception of the nurse-client interview. It was also beneficial to be able to check with the client if it was suspected that the nurse had overlooked data or that the client was unsatisfied with the intervention offered. The nurse could then be questioned further using the information obtained from the client. Data obtained through observation could be cross-checked in the interview. The nurse's evaluation of the client could also be cross-checked against the notes recorded on the client's record. Thus validation of data was possible by utilization of several data sources.

Development of Client Categories

Another problem in an ethnographic study is determining when sufficient data have been collected. One difficulty in this study was in setting the boundaries on the categories of clients seen by the nurses. Observation of clients in the waiting room confirmed that few fathers came to clinic with their children. Young adult males and retired males formed the principal group seeking immunization or vaccination. Use of client records at the end of the clinic enabled the researcher to establish the age range for infant and pre-school visits. The nurse's weekly records and the clinic annual reports were used to validate the types of home visits most commonly made by nurses. The fact that this was variable across district was confirmed in discussion at district meetings and in general conversation with individual nurses. These data were used as a check on the types of nurse-client visits observed in clinic, home and school. The clientele that attended Greenfield clinic differed in many respects from the clientele at Richmond, so the visits observed for each nurse were unlikely to include clients from all possible categories; this might never have been achieved even over an extensive period. A decision had to be made on the commonest categories by age and sex in the clinic; by grade and activity in the school and by type of visit in the home. Once all these categories were observed for each nurse observations were terminated. As clientele would vary from clinic to clinic it is probable that if the study were replicated new client categories would have to be established. Dingwall's (1978) categories for clients and nursing situations were used as a cross-check but were not found to be appropriate to the observed situation.

Data Analysis

The week's withdrawal at the end of each four week data collection period proved to be essential. It allowed time for transcription and preliminary analysis but more importantly it allowed contact and discussion with persons uninvolved in the study. Discussions took place with other nurses but also with non-nurses. The perspectives of both groups were critical in stimulating thinking and suggesting possible patterns of data organization. In future studies a team approach is recommended to data gathering and analysis. While it is advantageous to be a nurse in the situation the insight of non-nurses helps guard against the risk of overlooking the familiar. While transcribing tapes was an arduous business it increased the researcher's familiarity with the content and provided the basis for questions used in the second and third interviews. Familiarity with content was not as great in the few tapes that were transcribed by persons other than the researcher.

Giving each nurse her own case-study to read provided an opportunity to validate the data presentation. While most comments were editorial, some input allowed further clarification of situations. One difficulty was that the nurses reacted by seeing some incidents as relatively unimportant whereas the researcher saw them as critical incidents. Kratz (1975) reported that one difficulty she encountered was that the nurses in her study could not understand why the observer, who was a nurse, held a different opinion on what was and what was not valued work when she checked her data with each nurse.

The use of two nurses to check the selection of data and the emerging models with the interviews and field notes increased the reliability of the interpretation. Due to the amount of data collected it was not possible for either of these individuals to check all the data. This again points to the value of a team approach to studies that use ethnographic methods.

Summary

An ethnographic approach to the study of nursing was viable. It allowed observation of the nurse-client visit as it occurred followed by immediate clarification of the perspective the nurse held of the interaction. Differences in perception between the observer and the nurse could thus be clarified. The effect of the observer on the interaction does not appear to be sufficient to distort the data, although the effect was apparently greater on the nurses than on the client.

It is likely that there was some pre-selection of the clients that the nurses selected for home visits while the observer was with them. This was not the case in the schools or in the clinic and emergency calls in the home situation offset the pre-selection process to some extent. Some changes in the nurse's behaviour did occur over time in relation to the fluency with which they evaluated the nurse-client interaction and also with regard to the notes they made on the client's record.

The observer will always have to make some ethical judgements in the clinical situation and decisions can not always be covered by guidelines. Decision making occurs in both data gathering and the analysis stages of the study.

Taking part in the events of the clinic on a daily basis allowed for much informal data gathering which could be used to validate information obtained in more formal settings. Informal conversations frequently provided insights into the nurse's perspective that had not previously been obtained. This led to a richness of data that could not have been obtained through formal interview and intermittent observation.

Because of the need to check reliability of interpretations a team approach would be of value in an ethnographic study. The value of such a team would be enhanced if the composition included both nurses and non-nurses.

Implications For Nursing

This study was designed to describe and explain four nurses' perspectives of nursing in a community setting. It brings to the reader the results of direct observation and participation in the nurse-client interaction and the life of the clinic for a period of five months. Given that this study was conducted in one setting with only four nurses caution must be utilized in drawing generalized implications from this study to the entire world of nursing. It is possible however to draw some implications for nurses, nurse-educators and prospective nurses.

The four nurses worked at developing and maintaining nurse-client interventions which were meanginful to them and consistent with their interpretations of what constituted nursing in a community setting. What the nurses were trying to do was revealed as their definition of the situation. This was their perspective and the means by which they interpreted and made sense of their world and of the communications from the clients and from relevant others in the work situation. Each nurse developed an individual definition of the situation, which she utilized as her framework for practice. The relative isolation of each nurse's practice and the differences between the districts in which they worked encouraged the development of an individual perspective, particularly since there was a marked lack of feedback from administration, their clients or their peers. Dingwall (1977) noted this same pattern amongst practising health visitors he observed when studying the social organization of health visitors training. While it may well be valid for nurses to utilize different approaches, particularly given the different characteristics within the districts, it may be appropriate to ensure that more supervision is given to new public health nurses to aid them in evaluating their strengths and weaknesses.

The framework the nurses used to guide their nursing seemed to be rooted most strongly in their primary belief system, that is those beliefs that emerged in relation to their own lifestyle. It is probable that education only plays a secondary role, reinforcing beliefs already present. It has been suggested that users may adapt knowledge to fit their own needs or that there may be mutual adaptation between the user and knowledge producer (Larsen, 1980). The way in which the nurses dealt with procedural conflict suggests that adaptation of behaviour probably occurs as knowledge is acquired. Nurse-educators need to become aware of the students' values systems so they can help individuals recognize their own biases. However, this by itself is not sufficient, the nurses who had been through the values, attitudes and practice session recognized their values but still appeared unaware that client situations in which they felt frustrated frequently had at their roots a clash of fundamental values. Ujhely (1968) suggests that if a nurse notes the things that patients (clients) do that bother her most she may assume that one of her cherished values has been violated. It is evident that more work should be done with nursing students to help them to identify such situations. While the four nurses in this study all believed it to be important to let the client make their own decisions, they did not recognize the situations where their own deep seated values interfered with this process.

Another area of difficulty was related to gathering information about the client. Two of the four nurses were not comfortable moving beyond the acquisition of surface data. That is they were unwilling to move beyond the persona or outer covering that man puts on to perform his various social roles (Reich, 1960). Yet Reich argues that it is in the middle layer of man that many potential problems are supressed. Thus the overtly expressed problem may hide a deeper, more complex, situation. There is thus a need to be alert to covert cues which may give leads to indicate that the nurse has a problem-to-find rather than a problem-to-solve in any given situation.

In this community setting there was a singular lack of feedback for the nurses, from administrative sources, from clients (due to the lack of continuity of contact with most clients), and from their peers if the district was geographically separated from the clinic setting. These factors all helped the individual nurse to maintain her personal perspective. In recalling the literature reviewed Warren (1975) spoke of the effects of the relative isolation of the teacher in the classroom. Warren found that teachers perceived evaluation as based on tangible things, such as grades. The nurses in this study placed emphasis in their school work on screening and immunization. They saw these as agency priorities and even when these tasks prevented them from becoming involved in activities they personally saw as important they completed them. This perception is supported by a survey of studies which evaluated agency programmes that showed the measurement to be quantitative; that is the number of clients who took part in the activities was used as a measure of effectiveness, while the quality of service went unexamined (Highrighter, 1977). It is probable that while the nurses were not specifically told screening and immunization were priorities that they were nonetheless socialized to agency values as was the case with student health visitors in Dingwall's (1977) study. With the case loads the nurses carried in the school, if they were to reach an acceptable standard for numbers of children immunized (the goal was 85% of the population), then it had to be a priority activity. Such long-term goals as decreasing adult hypertension by screening for potential childhood obesity and preventive intervention are not readily measurable and therefore do not reflect on the perceived competency of the nurses, unless evaluation is based on observation of nurse-client interactions.

In summary, there are two major implications that arise from this study. The first is that each nurse had an individualistic approach to nursing care even though the approach was based on theoretical concepts which guided her practice. The second implication was that, once employed, the nurse received little feedback on her effectiveness, thus her relative isolation, except in the clinic setting, ensured that outside influences did little to change her perspective.

The study demonstrates that an ethnographic approach is viable as a method of examining nursing in the practice setting.

Recommendations

If the proposition is accepted that a framework for nursing is individualized by each nurse this raises some important questions relating to nursing education. On the basis of the study of four nurses recommendations for change cannot be made, but the following implications must be seriously considered in relation to both basic and continuing education.

First, much time and effort is spent in many schools of nursing developing standarized conceptual models of nursing on which to base the curriculum. It may well be more appropriate to teach students why a framework is relevant as a guide to practice and then to help them identify the components of the framework within which they operate.

Secondly, a student may identify her own values but still need help in recognizing the effect of her values on the nurse-client interaction. Thus, recognition of the role of values in nursing care should take a more significant place within the educational program.

Third, there is a need for nurses to develop greater skills in the collection and utilization of data. In the community setting the nurse needs to utilize several strategies in finding and solving problems. In educational programmes attention needs to be placed on finding problems as well as on solving problems.

Fourth, while much effort was put into inservice by this agency, educational programmes were of a global nature, meeting agency rather than individual needs. The relative isolation of the nurses did not allow for feedback on the effectiveness of their practice. Community health agencies do need to carry out systematic evaluation of employees, the purpose being to diagnose strengths and weaknesses of nursing interventions, so inservice can be directed toward remedial education.

Fifth, all four nurses were frustrated by non-nursing activities, which they viewed as taking time away from client care. There appears to be a need to evaluate both the effectiveness and efficiency of current methods of record keeping. Within the schools the expectations of what the nurse is expected to accomplish needs re-evaluation given the constraints of time and case-load.

Need For Further Research

This study of four nurses in a community setting raises many questions for future study. Would nurses in a different context have different perspectives or would there be similar elements in their models to those identified by nurses in the community? Would secondary socialization play a bigger part in influencing perspectives in a hospital setting where nurses are less isolated from their peer groups? Do nurses from diploma programmes also operate from a theoretical model? Are nurses' perspectives of nursing determined largely by the life characteristics of the individual or was this unique to the subjects in this study? These are a few of the questions which suggest a need for continued research on nurses' perspectives on nursing and their influence on client care.

One other area that needs further research is the way in which nurses process information. There is evidence in this study that data input is extremely varied and that relating cues is a complex process. There was some evidence to suggest that data processing was inadequate but study is needed to determine how nurses process data before it can be determined where the inadequacies in the process occur.

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APPENDICES

APPENDIX A

CLIENT CONSENT

CONSENT FORM

Project: Study of Community Health Nursing

Investigator: Peggy Anne Field, R. N.
Department of Elementary Education
University of Alberta
Edmonton, Alberta
T5J 2L5

I hereby consent to participate in this study and to allow the researcher to observe and/or tape the interview with the community health nurse. I understand that whatever information I give is considered confidential and will be used in such a way as to protect my anonymity.

Date ______________________

Principal Subject ______________________

Witness ______________________

APPENDIX B

INITIAL INTERVIEW GUIDE

INITIAL INTERVIEW GUIDE

1. Tell me how you became interested in Community Health Nursing?
2. Could you begin with the start of a typical day. From the moment you open the door and come into the clinic and describe what you might do, what kinds of people you may see, where you may go, until you leave to go home at night?
3. What are your priorities in your job?
4. What do you like best about public health nursing?
5. What things frustrate you in public health nursing?
6. Can you tell me about one client or situation that you found rewarding in the last couple of months?
7. Can you tell me about one client or situation that you found frustrating in the last couple of months?
8. How do you allocate time in planning what you have to do?

APPENDIX C

SECOND INTERVIEW GUIDE

SECOND INTERVIEW GUIDE

1. How would you describe yourself as a person?
2. You spoke of the importance of identifying client needs. How do you know when you are meeting these needs?
3. What do you think you bring to nursing?
4. Do you take nursing home with you? Do you think about nursing at home?
5. How important to you is respect when working with clients?
6. We talked about the frustrations in your job -- does this affect what you do with clients? If so to what extent?
7. Do you ever consciously think about agency regulations/policies when you are planning or making visits to clients?
8. Do you perceive any difference between the way you function in clinic and the way you function at home or in school in relation to client interaction? Why?
9. Do you feel that the stresses that have been identified in the administrative system affect your nursing in any way?
10. How do you deal with the stresses in the system?
11. What do you see yourself as doing to help develop a group feeling in the clinic?
12. Who do you use as a support system when you need it in the work situation?

APPENDIX D

D-1 THIRD INTERVIEW GUIDE - CAROL
D-2 THIRD INTERVIEW GUIDE - RUTH
D-3 THIRD INTERVIEW GUIDE - KATE
D-4 THIRD INTERVIEW GUIDE - LOIS

THIRD INTERVIEW

CAROL D-1

1. I have heard the words "promotion" and "prevention" used to describe the role of the public health nurse. What is the difference between promotion and prevention?

2. I have heard the words "patient" and "client" used. What is the difference between a patient and a client?

3. How do you see yourself using situational (practical) information and theoretical (nursing, psycho-social theory, recent articles) in identifying a client's problems and taking action?

4. In what ways do you evaluate the success of your nursing actions when working with clients?

5. What do you feel you achieved with the C--- family?

6. You had two T.B. patients on your case list in October. One, a woman (Dolores), went back to the reserve and you said "Thank goodness". She had not completed with her regime and had not picked up her medication. The other was Charles, who also did not comply with his medication orders, yet you persevered with him. Can you expand on these situations for me.

7. In the schools you told me about a student teacher's annoyance when you declined to remove a sliver from a child's hand, and said that primarily the parent should be given the responsibility. You also said it was not strictly within your job description. Yet on the visit to the family with diptheria you helped the older boy with his math homework, which also is not strictly within your job description. What were the differences between these two situations.

8. You have spoken of dependence and independence frequently. Is dependence always a negative factor in individuals? What about interdependence?

9. You have spoken of individuals as not having a "good life". Can you expand on your interpretation of a good life?

10. a) When you make a home-visit, what do you assess to determine the level of functioning within the home?
    b) What specific things do you look for in a post-partum visit.

11. In your area, ease of access to a home was frequently difficult. Do you use this to assess family function -- if so in what way? Do you use it for any other purpose?

12. You have said that one of your major foci is to help the individual focus on the decision-making process. What are the elements of decision making? Does this differ from problem-solving?

13. How does your role as assistant supervisor differ from your role as district nurse? Do you have any difference in your level of satisfaction in your new job?

14. How do your new activities fit into your philosophy of helping others to develop decision-making skills?

15. Do you have any preference for working with boys rather than girls? Or men rather than women?

THIRD INTERVIEW

RUTH

D-2

1. I have heard the words "promotion" and "prevention" used to describe the role of the public health nurse. What is the difference between promotion and prevention?

2. I have heard the words "patient" and "client" used. What is the difference between a patient and a client?

3. You said in the first interview that you believe client education is your first priority in public health nursing.
   a) What are the different activities involved in client education?
   b) How do you identify clients' educational needs.

4. a) What are the different activities you engage in when teaching a single client and a group of clients?
   b) What differences are there between learner activities in the two situations.

5. Do you see yourself as adapting your teaching in a 1:1 situation to meet individual needs? Can you give an example?

6. In what ways do you assess the effectiveness of your teaching?

7. In clinic one afternoon we saw two young babies. The first was 2 1/2 years old and the mother was concerned about overfeeding. You told her you would ask the district nurse to visit. The second was a five day old baby with thick mucus in his nasal passages; you also told this mother you would ask the district nurse to make a priority visit. In neither case was the contact with the district nurse followed through. Would you comment on this?

8. How do you see yourself using situational (practical) information and theoretical (nursing, psycho-social theory, recent articles) in identifying a client's problems and taking action?

9. When you make a post-partum home-visit, what do you assess to determine how well the mother is functioning?

10. Are there any specific things you look for in making an assessment of the situation in a home visit (eg. school, bereavement).

11. You often say a mother is "on top of things" -- can you expand on this and tell me what you mean?

12. You often say a mother "seems comfortable with her baby" -- can you expand on this and tell me what you mean?

13. You said you would not mind working part-time so you can spend more time with your family, yet you are active in the S.N.A. and teach prenatal classes regularly. This seems somewhat contradictory. Could you comment on this for me?

THIRD INTERVIEW

KATE D-3

1. I have heard the words "promotion" and "prevention" used to describe the role of the public health nurse. What is the difference between promotion and prevention?

2. I have heard the words "patient" and "client" used. What is the difference between a patient and a client?

3. How do you see yourself using situational (practical) information and theoretical (nursing, psycho-social theory, recent articles) in identifying a client's problems and taking action?

4. When we discussed your hygiene visit from R---, you said that because you did not see the mother's change in behavior as permanent, you did not see your own needs being met. Can you expand on this for me?

5. In what ways do you evaluate the success of your nursing actions when working with clients?

6. At A--- you saw a lady who was six months pregnant, who had two children under four and many social problems. You suggested she came to prenatal classes and spent time talking about both classes and available literature. Why did you make the decision that this was a priority?

7. a) In what ways do you think that your belief that priorities should be based on individual needs affects your weekly work pattern?
   b) Do you think there is a difference between the way you organize your time and the way other nurses in the clinic do so?

8. a) What is the difference between R--- and St. N--- in terms of the activities you undertake in the two schools?
   b) What influence does your preference for one or other school have on your activities?

9. a) A teacher comes to you with a problem about a child, for example, the C---. What are the actions you would take in the situation?
   b) Is there a difference in your actions depending on the age of the child?

10. What differences are there between your role in well child supervision and that of the doctor?

11. What actions have you taken to try to change the time spent on records in the schools?

12. You have said that immunization is not a priority amongst your mothers, and I have observed that you received a larger number of follow-ups of mothers who have not been to clinic than other mothers. How do you go about getting them to come?

13. When you make a post-partum home-visit, what do you assess to determine how well the mother is functioning?

14. Are there any specific things you look for in making an assessment of the situation in a home visit? (eg. school, bereavement).

15. You have said you prefer making an unannounced home visit to a planned one. Will you comment on this.

16. At R---- on 11 November when the Remembrance Service was held, several children fainted or felt faint, but you left it to the teacher and did not check them, although you were aware of it. On another occasion two girls went to the washroom with bruises from physical education. You checked these two. Would you comment on these two situations?

THIRD INTERVIEW

LOIS

D-4

1. I have heard the words "promotion" and "prevention" used to describe the role of the public health nurse. What is the difference between promotion and prevention?

2. I have heard the words "patient" and "client" used. What is the difference between a patient and a client?

3. How would you describe your own activities related to promotion and prevention?

4. How do you see yourself using situational (practical) information and theoretical (nursing, psycho-social theory, recent articles) in identifying a client's problems and taking action?

5. In describing how you see a mother following a visit, you have said "I think she's a good mother".
   a) Can you expand on this and tell me what you mean?
   b) Can you describe two mothers, one whom you feel is functioning as a "good" mother and one who is not.

6. What are the different activities involved in case-finding at-risk families?

7. a) What are your feelings about Richard's family and your ability to get them mobilized?
   b) What activities do you see yourself engaged in when working with this family?

8. What differences are there between your role in screening high risk infants and the role of the G---?

9. With the H--- family, there seems to be some concern about the maternal-newborn relationship, yet no one seems to be taking any action or follow-up of this family. Can you comment on this?

10. Can you tell me how you decide to terminate your visits to an at-risk family?

11. When you make a post-partum home-visit to an at-risk family, what do you assess to determine how well the mother is functioning?

12. Are there any specific things you look for in making an assessment of the situation in a home visit? (eg. school, bereavement).

13. You speak of "adequate" basic care in relation to mother-baby care. Could you tell me what the different activities are that are involved in basic care?

APPENDIX E

POST VISIT INTERVIEW

APPENDIX E

POST VISIT INTERVIEW WITH NURSE

1. Can you tell me what you thought was important in that interview?
2. What decisions did you make about the client?
3. What was theere about the client that led to your conclusions?
4. What was there about the situation that led to your conclusions?

APPENDIX F

GUIDE FOR INFORMAL PROBE INTERVIEWS

APPENDIX F

OUTLINE FOR PROBE INTERVIEWS

These questions show examples of the types of content likely to arise.

A. Structure Questions

1. What are the different activities ....(involved in health promotion)?
2. What are the different kinds of..........(clients that you see)?
3. What are the different ways to ....(gain access to a home)?

B. Attribute Questions

1. What is the difference between ....(guidance and counselling)?
2. What differences are there between ....(your priorities and administrative priorities)?
3. What differences are there between ....(the social worker and the nurse) (pre-school and school age services) (clients and patients)?

APPENDIX G

EXAMPLE OF NURSE'S ACTIVITY RECORDS FOR ONE WEEK AS RECORDED BY THE OBSERVER

TIMETABLE OF WEEKLY ACTIVITIES

Week 5/11/79 Carol

Day/Date	AM	Time	PM	Time
Monday 5/11/79	Elementary School	8:45	Elementary School	
	Check in office	9:00-9:15	Records	1:30
	Make appointment GI Teacher	9:15	Phone call: referral on Robert	1:55
	Records (Requests)	9:35	Report back to school counsellor re: Robert	2:05
	Phone call: referral child to doctor	10:20	Teacher consultation	2:25
	Coffee: staffroom (Talk to teachers)	10:30	Review of GI class with teacher	2:30
	Informal Conference re: Robert		Home Visit re: Robert	3:35
	Lunch	12:00	Clinic: Write up notes re home visit	4:20
Tuesday 6/11/79	District Meeting		Central Clinic Personal Business	
			Home Visits: New Baby (not home)	
			New Baby (not home)	
			Tuberculosis Follow-up	
			Clinic: Records	
Wednesday 7/11/79	Prenatal Resources Committee		Elementary School: Preparation for Immunization (Records/Lists, etc.)	
Thursday 8/11/79	Genetics Inservice		Clinic: Phone calls: Robert's father	
			Phone call: B.Sc.N. student consultation re: family	
			Mother + 6 months. Immunization and counselling	
			Mother + 13 months. Immunization and counselling	
Friday 9/11/79	Cumulative leave day			

TIMETABLE OF WEEKLY ACTIVITIES

Week 4/2/80 Ruth

Day/Date	AM	PM
Monday 4/2/80	Clinic: Preparation of School Report Preparation of Workshop Report	Clinic: Adult (F): Shick Test Adult (F): Travel Immunization 11 month: DDST and Immunization 1 year: DDST and measles 2 week: Initial Clinic Visit/Crisis Adult (H): Read T.B. Test Phone Call: From parent of school child re immunization Phone Call: re student orientation to public health (hospital) Phone Call: consultation with mother re breast feeding
Tuesday 5/2/80	District Meeting	Junior High School: GVI Baby Sitting Class Home Visit: New Baby
Wednesday 6/2/80	Prenatal meeting - City Committee	Mother + 7 month: Immunization and counselling Mother + 7 month: Immunization and counselling Mother + 8 weeks: First routine clinic visit Mother + 10 months: Unscheduled: guidance re: feeding Mother + 18 months: Booster shot and counselling Mother + 5 months: First clinic visit
Thursday 7/2/80	Elementary School Records 9:00-10:15 Phone call: Mother re: tetanus shot for camp Vision check: 3 Student from G.V. (borderline in GIV)	In-Service: Values, Attitudes & Practice Workshop (V.A.P.)
Friday 8/2/80	V.A.P.	V.A.P.

TIMETABLE OF WEEKLY ACTIVITIES

Week 7/1/80 Kate

Day/Date	AM	PM
Monday 7/1/80	Elementary Schools (Snowden) Call on Secretary 8:15 Deliver notes to students for parents re: immunization 8:30 Arrange with teachers for children to leave class for vision check 8:40 Records (Immunization 8:50 Vision Screening Grade II (16 students) 9:15 Coffee Break: Talk with teachers 10:30 Grade I: Teacher Conference 10:45-11:30 Records 11:30-12:00	Snowden Vision Checks Grade IV (10 students) 1:00 Records 2:30 Attempted home visit x 2 3:30-4:00 (not home) Return to clinic with records
Tuesday 8/1/80	District Meeting	Snowden Return Parent Calls 1:30 Phone Parents re immmunization 1:45 Vision testing (14 students) 1:45 First Aid: Frozen Hand To clinic to get records for Wednesday
Wednesday 9/1/80	Richmond Clinic 8:30-12:00 Mother + 8 week and counselling Mother + 14 day and counselling Mother + 1 year Immunization and counselling Mother + 4 month, DDST Guidance, Immunization	Snowden Prepare Immunization Sheets Home Visit: Single mother, post partum, feeding problems

(continued)

TIMETABLE OF WEEKLY ACTIVITIES (continued)

Week 7/1/80 Kate

Day/Date	AM	PM
Thursday 10/1/80	Elementary School (Snowden) Check for parental consents Check health records Follow-up call to parents of children from vision screening First Aid: Minor injury in physical education class	Get immunization materials (needles, syringes, biologicals) ordered for Friday
Friday 11/1/80	Immunizations all morning Four nurses involved	Complete records, notes, to parents, etc. on all children immunized

TIMETABLE OF WEEKLY ACTIVITIES

Week 26/11/79 Lois

Day/Date	AM	PM
Monday 26/11/25	Central Office: Infant and Pre-School Committee	Clinic: Mother + 18 month, DDST, Immunization and counselling Phone doctor re flu vaccine Mother + 3 month counselling and immunization Adult Male: T.B. Test Phone call from mother: re feeding problem Consultation with another nurse (immunization) Phone call: adult, travel protection Mother + 10 month old counselling Mother + 1 year old counselling and immunization
Tuesday 27/11/79	District Meeting	Home Visits: Two not at home (no telephones) Follow-up 8 week old child with congenital anomaly Follow-up 6 month old, plus 2 year old with birth injury Follow-up with 4 year old, check on parental motivation to carry out prescribed treatment.
Wednesday 28/11/79	Clinic Check high risk families re clinic attendance Check nurses notes from clinic previous day	Clinic Mother + 16 week guidance and immunization Mother + 3 month guidance and immunization Mother + 3 year old DDST 2 month guidance Mother/Father + 8 week guidance and immunization Babysitter + 18 month measles vaccine

TIMETABLE OF WEEKLY ACTIVITIES (continued)

Week 26/11/79 Lois

Day/Date	AM	PM
Thursday 29/11/79	City Inservice: Genetics	Clinic * Mother + 3 week old diaper rash * Mother + 3 month old rash Mother + 2 week old Physical Assessment and guidance (Clinic quiet this afternoon) * Visits lasted over one hour
Friday 30/11/79	Clinic/Records Telephone Messages	Clinic/Clients

Observer not in clinic 30/11/79. Activities reported by Lois.

APPENDIX H

AGENCY GUIDELINES FOR NURSE-CLIENT VISITS IN THE CLINIC

AGENCY GUIDELINES
SUGGESTED FOLLOW-UP ON NORMAL AND "AT RISK" BABIES

A. Post Natal Home Visit - all infants

1. Check history of family and child for At Risk categories not covered on birth registration notice - eg. jaundice, family history and socio-economic situation.

2. Ascertain likelihood of good health care and supervision to determine degree of follow-up supervision required.

B. Two (2) Months (or first visit) - physical examination - all infants

1. Measurements (height, weight and head circumference recorded in cm)

2. General physical examination (stripped)
- check for symmetry, movement and muscle tone; also congenital abnormality (palate, hips, skin)

3. D.D.S.T. as part of 2, time permitting. Record any unusual findings on chart. Record on Denver sheet if time permits. Check hearing and Vision as per D.D.S.T.

C. Four (4) Months - development assessment - all infants

1. Measurements

2. Physical examination only if specific follow-up information required. Check hips.

3. D.D.S.T. - note quality of performance ie. poorly performed, accurately and quickly performed: ask mother if performance has been usual behaviour.

4. Hearing - as per D.D.S.T. using bell and rattle.

5. Vision - symmetrical (or minimally off-center) reflection of light from pupils. Follows horizontally 180°.

It is recommended that D.D.S.T. be done at home on A.R. not likely to come to clinic.

D. Eight (8) Months - D.D.S.T. - if not done here - do at 12 months.

E. One (1) Year - developmental assessment - all infants

1. Measurements

2. D.D.S.T. - (if not done at 8 months).

3. Vision - cake decoration test

4. Hearing - a) say infant's name or 'baby') child should
   b) high pitch sound 'ss' or 'kk') turn head
   c) low pitched sound 'oo') 45° to sound

5. Arrange for medical if concern or inadequate health supervision.

6. If no concern remove all but categories 1, 2, 3 and 10 from registry.

F. Eighteen (18) Months - developmental assessment - 1, 2, 3, 10 only

1. Measurements

2. Physical examination if follow-up information required.

3. D.D.S.T.

4. Hearing and/or Vision if any concerns.

5. Remove category 10 from registry if NO concern re health or environmental status.

G. Three to three and a half (3 - 3 1/2) Years - D.D.S.T. categories 1, 2, 3 and 10 requiring surveillance.

1. Book into clinic on appointment basis, if possible.

2. Hearing, if concern - Puretone.

3. Vision, if concern - Allen picture.

While the D.D.S.T. is a screen, the nurse's background provides her with the ability to make judgment as to the quality of child's performance. Observations can be utilized as a basis for discussion with the parent regarding developmental stimulation in the home. Parents of children having lags on D.D.S.T. should be encouraged to bring child to the City of Edmonton Health Department physician. If child is referred to family physician, send copy of D.D.S.T.

Public Health Nursing Division March, 1979

COMMON INFANT & PRESCHOOL CONCERNS

The following are very broad outlines of advice for the more common childhood complaints. Please

a) always check mother's source of advice;
b) refer mother to doctor if in any doubt;
c) if you can't help her, don't make her mad!

1. FEEDINGS

a) Please refer to feeding schedule.
b) If changing feeding, do so gradually.
c) Special feedings (only doctor changes); eg. Isomel, goat, Prosobee, Mullsoy, Chofree, Lofenolac.

2. RASHES - I. IN DIAPER AREA - Suggest

a) No Fleecy, Downy, Borax, bleach or detergents. Suggest Maple Leaf Flakes or any other pure soap flakes. (Ivory Snow contains detergent).
b) Several clear rinses.
c) Vinegar to soak diapers (1/2 cup to a gallon).
d) Expose area to air.
e) No rubber or plastic pants.
f) Use of vaseline, Glaxal or Lanovan to protect area - occasionally or at night - after soap and water washing.
g) Cornstarch as powder.
h) Cranberry juice (1/2 cup juice to 1/2 cup water) if over 6 months.

- II. ON FACE

a) No soap
b) Aveeno (non-soap)
c) Check for cradle cap

- III. IN OTHER AREAS

a) Mazon ointment, only for minor Eczema-like rashes.
b) Look for causes (rubber? plastic? wool? new food?)

- IV. TINEA (RINGWORM)

a) Tinactin.

- V. IMPETIGO

a) Polysporin t.i.d. for three days. Check back to clinic
b) Remove crusts

- VI. INTERTRIGO (behind ears or in groin)

a) Vaseline, Glaxal or Lanovan
b) If appears infected - Polysporin

3. THRUSH

a) Antifungal agent four times a day for three days, eg. mycostatin (prescription required)
b) Dequadin.
c) Cleanliness of nipple and soother (boil)
d) Check re vaginal discharge in mother. (see Dr.)
e) Check for diaper rash.

4. INFECTED TEAR DUCT

a) Wash with cool, boiled saline (1/2 tsp. per cup water)
b) Cleanliness (wipe toward tear duct)
c) Massage lachrymal sac from top to bottom.
d) Refer to doctor if persistent.

5. FEVER

a) Phone doctor.
b) Aspirin (children's size) - grs. 1 1/2 x q4h x q.i.d. only. Never give aspirin if vomiting.
c) Tempra gtts. - .6 gtts. t.i.d. for ages 1-4; .3 ggts. up to 3 doses q4h for under 25 pounds
d) Fluids
e) Sponge
f) No routine aspirin or Tempra following immunization. Use only if previous reaction has been fever.

6. COLDS

a) Steam
b) Fluids
c) 1/2% neosynephrine 5-10 minutes before feeding, q4h only - 3 gtts. in each nostril for three days.

7. DIARRHOEA - until mother can consult Dr.

a) If child is otherwise well, and voiding, take off solids and give clear fluids, eg. half strength apple juice, warm Coca Cola or ginger ale (flat), or 2 tbsp. sugar to 24 ounces water.
b) Resume formula half strength when no diarrhoea for at least 12 hours.
c) Resume solids very gradually.

8. CONSTIPATION

a) Check symptoms and diet (breast)
b) Give extra fluids
c) Don't boil milk
d) Add brown sugar or honey
e) Try prunes

f) Check mother's attitude to bowel movement.
g) Explain baby's straining at stool - lying on back.

9. CRADLE CAP

a) Ordinary cooking oil overnight if crusted
b) Head & Shoulders followed by brisk rubbing with terry towling.
c) Fine comb.
d) Persevere - may take one week.

10. VOMITING

a) Consult doctor

Revised May, 1976.

APPENDIX I

AGENCY GUIDELINES FOR INFANT FEEDING

GUIDELINES FOR INFANT FEEDING

Breast feeding with Vit. D. Supplement
or Milk Formula e.g. Enfalac, Similac, SMA

if Mom using cow's milk - dilute till approx. 6 months

	Milk	Water	
Whole bottled milk	24 oz.	+ 6 oz.	
2% bottled milk	24 oz.	+ 6 oz.	+ 2 tbsp. sugar
Evaporated whole cow's milk	12 oz.	+ 18 oz.	
Evaporated 2% cow's milk	12 oz.	+ 18 oz.	+ 2 tbsp. sugar

Vitamin supplement and/or juice

Solids: not necessary until baby reaches 3 months of age
3 months: Pablum - encourage extra water

4 months: Vegetables - green or yellow
small quantities at weekly intervals.

5-6 months: Meats and egg yolk

Encourage blended foods - minimal amount of salt and sugar